Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Best Care. Right Place. Right Time.
2011-2012 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Table of Contents

Vision, Mandate, Mission and Values....2

Message from the CEO and Chair....3

The HNHB LHIN Board of Directors....5

Continued Evolution of the HNHB LHIN....7

Snapshot of the HNHB LHIN....8

Engaging our Communities....11

Working Together for Better Quality Care....16

Advancing Our Priorities....20

Performance Indicators 2011-12....38

Financial Statements and Notes to the Financial Statements....43

Hamilton Niagara Haldimand Brant Local Health Integration Network

Vision, Mandate, Mission and Values

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need access to local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real Conversation

Message from the CEO and Chair

Over the past year the HNHB LHIN staff and Board members have worked tirelessly toward creating an integrated health care system that serves people and their families best. In 2011-12 we made great progress toward this goal and this report will provide you with a snapshot of the goals achieved as well as the continuing challenges.

We worked to improve quality.
Improving the quality of care within our LHIN is a key priority. The Quality and Safety Committee (Q&SC) of the Board of Directors provided guidance on our efforts to improve system-wide quality improvement.

The Board reviewed the LHIN's progress across a number of key indicators to determine key priorities to address safety, effectiveness, access and patient satisfaction. Based on this evidence, the committee selected to focus on diagnostic imaging, orthopedics and hospital avoidance as key priorities. These priorities are consistent with the *Excellent Care for All Act (ECFAA)* and the LHIN's obligations to the Government of Ontario through its accountability agreement. Scorecards to track improvements were implemented for each area, and the LHIN continues to work with providers on these priorities.

The LHIN engaged governors and staff from hospitals and the CCAC to collectively share successes and joint work on the first and second years of the Quality Improvement Plans (QIPs) as required under ECFAA. This work has led to a commitment by providers to come together to address the key challenges in developing aims, measures and practice changes to improve the quality and experience of patients as they move across the health care continuum.

We continued to advance quality care in our hospitals and long-term care homes with important initiatives like Senior Friendly Hospitals and Residents First.

In the third and final year of the LHIN's candidacy to become a Best Practice Spotlight Organization (BPSO) through the Registered Nurses' Association of Ontario (RNAO), 12 health care provider organizations continued to work together to implement, across the LHIN, best practice guidelines for clinical practices.

We worked to enhance access to care.
Using a bundle of targeted strategies, the LHIN achieved the lowest acute Alternate Level of Care (ALC) rate, 12.97%, since 2007 when it was 25.55%. This means that more people received the best care in the right place at the right time. Together with our health care providers, we worked to transition people to a long-term care home resulting in a record low number of individuals waiting in hospital for a long-term care placement.

As a result of working together with our hospitals, people are now waiting less time to have Magnetic Resonance Imaging (MRI) and Computerized Tomography (CT) scans. As of February 2012, these wait

times are *below* the LHIN target! The MRI wait time is the lowest it's been since April 2009 and is below the provincial wait time, and the CT wait time is the lowest it's been since April 2011.

We worked with our community and mental health agencies to facilitate collaboration, partnerships, and integration to promote better access to and quality of service for an improved client experience.

We worked to provide better value.
The LHIN evaluated all of its Aging at Home (AAH) programs to ensure that they are meeting their intended objectives and are contributing to improved population health, client outcomes, and system sustainability. Investments in more than 75 programs have helped seniors return home safely and quickly after a hospital stay, avoid trips to the emergency department and get connected with supports and services in their communities to help them live independently at home.

The LHIN's Nurse Led Outreach Team provided more primary care assessments and treatments to more long-term care home residents, effectively enhancing quality care and reducing the pressure and wait times at emergency departments.

Through an innovative program involving Hamilton paramedics and the CCAC, more seniors avoided emergency department visits and hospitalizations by getting connected with supports and services in the community.

We are proud of the progress our LHIN team and all health service providers have made and the positive impact we've had on the lives of the residents we serve. After all, people and their families are at the heart of the work we do for health care in our communities.

We are motivated by the passion of residents, health care providers and stakeholders who are committed to building a health care system where people get the best care, in the right place, at the right time.

We are encouraged by the passion and diligence of our board, which this past year, was marked by a transition in membership. Following the term completions of Juanita Gledhill and Jack Brewer, the inaugural Chair and Vice Chair, Michael Shea and Bob Lawler were appointed Chair and Vice Chair respectively. We thank Juanita and Jack for their significant contributions to transforming the health care system while guiding the LHIN through and beyond its infancy. We welcomed new members Laurie Ryan-Hill, Nathalie Brown and Mervin Witter to the Board, and wished Bill McLean and Bill Millar well as they completed their terms. We are grateful to all who serve and have served on our Board for their efforts in building a person-centred and sustainable health care system. We are also privileged to work with a staff team whose tireless dedication and expertise continue to propel us forward.

While we have made a great deal of progress, we understand and know that there is more to be done and more hard work and action ahead of us. We look forward to a year of continuing to work together with all of our partners to create a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Sincerely,

Donna Cripps
Chief Executive Officer

Michael Shea
Board Chair

The HNHB LHIN Board of Directors

Left to right: Douglas Archibald, Laurie Ryan-Hill, Mervin Witter, Bob Lawler, Michael Shea, Ruby Jacobs, Bill Millar, Nathalie Brown, Helen Mulligan.

Juanita G. Gledhill, Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years
Term Completed: June 1, 2011

Michael Shea, Chair

Appointed: October 28, 2010 • Term: 3 years
Appointed Chair: June 2, 2011 • Term: 3 years

Jack Brewer, Vice Chair

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June 2, 2008 • Term: 3 years
Term Completed: June 1, 2011

Bob Lawler, Vice Chair

Appointed: October 29, 2008 • Term: 3 years
Appointed Vice Chair: June 2, 2011 • Term: 3 years

Douglas Archibald, Member

Appointed: May 9, 2007 • Term: 2 years
Re-appointed: May 9, 2009 • Term: 3 years

Ruby Jacobs, Member

Appointed: March 3, 2010 • Term: 3 years

Bill McLean, Member

Appointed: May 17, 2006 • Term: 2 years
Re-appointed: May 17, 2008 • Term: 3 years
Term Completed: May 16, 2011

Bill Millar, Member

Appointed: March 7, 2007 • Term: 2 years
Re-appointed: March 7, 2009 • Term: 3 years
Term Completed: March 6, 2012

Helen Mulligan, Member

Appointed: June 17, 2010 • Term: 3 years

Transitions in Board Membership

The year 2011-12 marked a transition period for the Board.

Effective June 2, 2011, Michael Shea and Bob Lawler took on the roles of Chair and Vice Chair respectively, as founding Chair Juanita Gledhill and Vice Chair Jack Brewer came to the end of their second three-year terms; the maximum that can be served.

The Board welcomed three new members: Laurie Ryan-Hill, Nathalie Brown and Mervin Witter. Laurie's three-year appointment took effect May 17, 2011. Nathalie and Mervin's three-year appointments were effective June 2, 2011.

After serving as Board members for a combined 10 years, the Board wished Bill McLean and Bill Millar well as they completed their final terms May 16, 2011 and March 6, 2012 respectively.

Relationship Between the Board and Senior Management

As of March 31, 2012, the LHIN Senior Team included the CEO and Directors of Communications and Corporate Services, Health System Transformation, Access to Care, Quality and Risk Management, Finance, and Physician Lead, Clinical Health System Transformation.

Senior Team members attend the regular Board business and education meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Senior Team guides strategic operations of the organization.

The Board provides ongoing direction to the CEO through:

- regular business and education meetings
- Board committees
- policy direction
- performance appraisal.

Continued Evolution of the HNHB LHIN

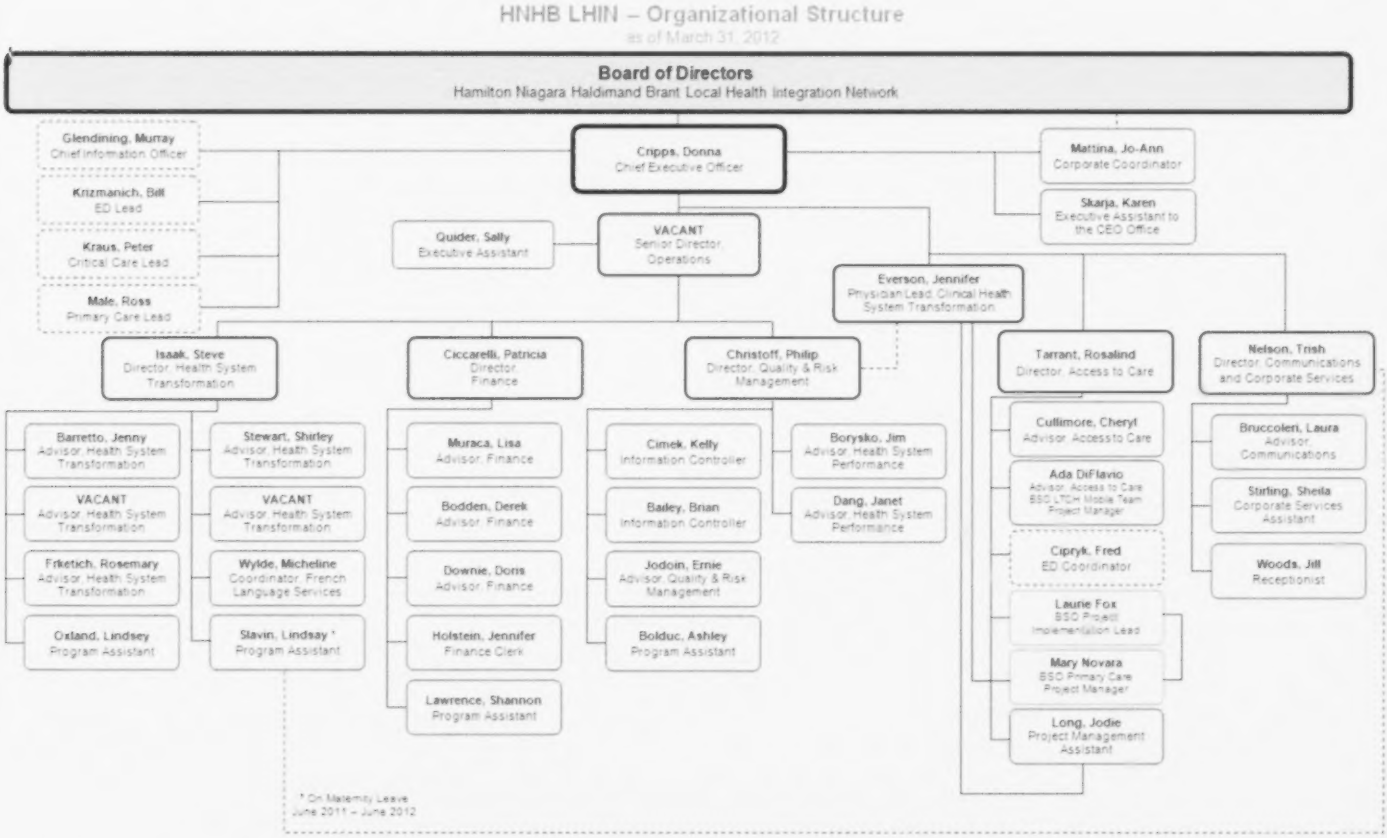
Our Organization

Staff

HNHB LHIN staff is committed to and passionate about working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren. It is this vision that guides them in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN and maximizes the skills, knowledge and expertise of staff. Staff remains committed to building capacity and sharing knowledge through further training and education, and participation in local, provincial, and national activities.

Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.



Snapshot of the HNHB LHIN

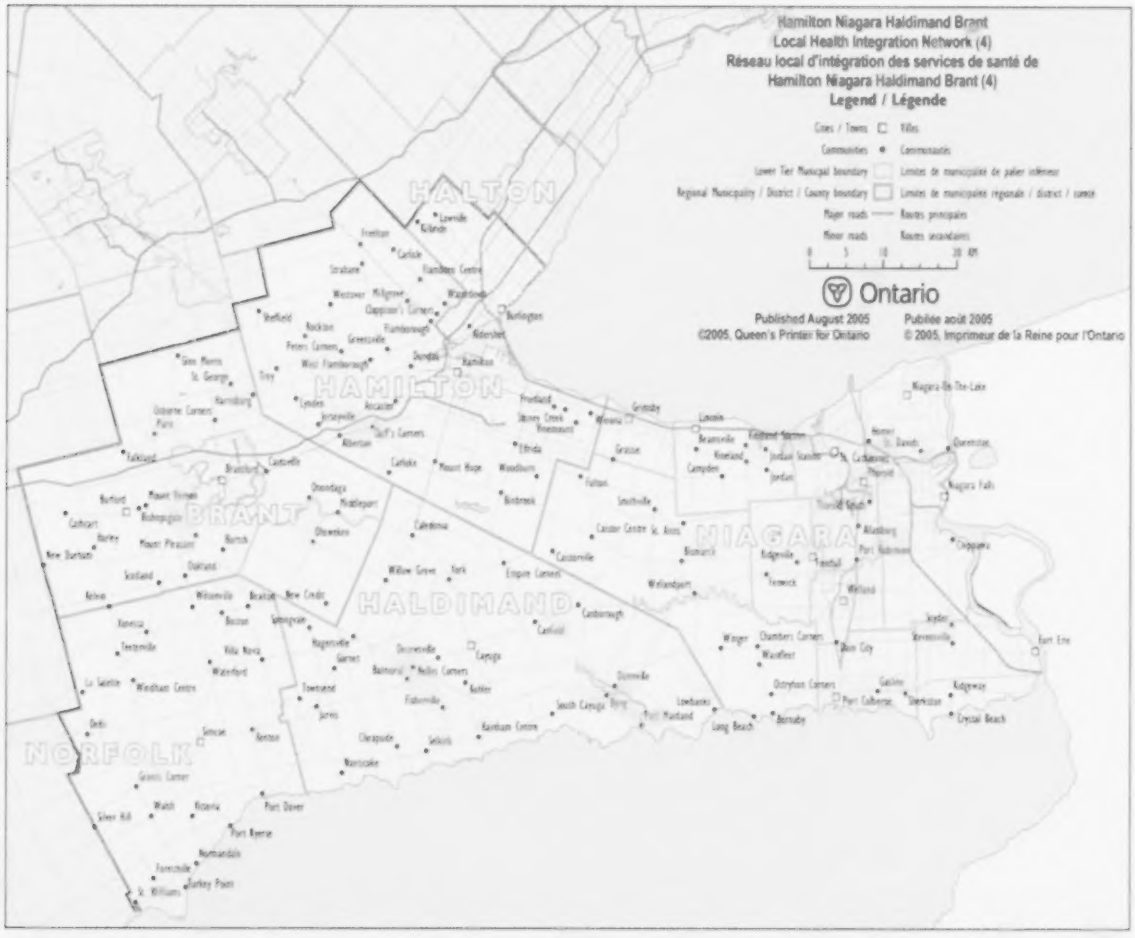
HNHB LHIN Population

Demographics

The LHIN is home to over 1.4 million people -- about 11% of the population of Ontario. The LHIN population is projected to grow 4.1% over the next five years, and 8.8% over the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

The LHIN's population is aging. The total number of people 65-74 years old is growing the fastest and the largest changes will be among people age 65-74 (45.2%) and 85 or older (33.4%) over the next 10 years.

As of 2011, more than 230,000 people age 65 or older live in the LHIN which is the largest number of seniors of all Ontario LHINs *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*



Socio Demographic Characteristics

The LHIN has a diverse population. For 18% of residents, neither English nor French is their first language. Francophones, First Nations, and urban and rural Aboriginal people are recognized populations in the LHIN. Compared to Ontario, the LHIN has a lower percent of immigrants and visible minorities.

There are two reserves in the LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and Mississaugas of the New Credit First Nation. The total registered Aboriginal population in the LHIN is approximately 24,000 people (1.7% of the total LHIN population) with about half the population living on reserve. Non-Status, Métis, and Inuit populations are not included in these population estimates *(Source: First Nations Peoples in Ontario: A Demographic Portrait. Ministry of Health and Long-Term Care, Health System Information Management and Investment Division. Health Analytics Branch, January 2009).*

The LHIN has a higher percent of lone parent families, and a lower percent of adults with post secondary education than the Ontario average.

	HNHB LHIN	Ontario	Range for all 14 LHINs
Total Population (2011)*	1,414,803	13,370,601	238,760 - 1,798,751
Senior population, age 65+ (2011)*	16.4%	14.1%	10.2% - 18.3%
Population with English mother tongue	79.2%	68.4%	49.6% - 90.9%
Population with French mother tongue	2.0%	4.1%	0.8% - 22.9%
Population who are immigrants	20.3%	28.3%	6.3% - 55.7%
Population who are recent immigrants (arrived between 2001-06)	2.3%	4.8%	0.3% - 9.5%
Populations who are visible minorities	9.1%	22.8%	1.4% - 50.3%
Population of Aboriginal identity	1.7%	2.0%	0.4% - 19.0%
Labour force participation rate (age 15+)	65.7%	67.1%	60.1% - 71.5%
Unemployment rate (age 15+)	6.0%	6.4%	5.2% - 8.4%
Population in low income (before tax) all persons	13.8%	14.7%	9.7% - 24.2%
Families (with children) headed by a lone parent	16.2%	16.0%	13.8% - 19.4%
Population (age 25-64) without certificate, degree, Diploma	14.6%	13.6%	9.0% - 20.3%
Population (age 25-64) with completed postsecondary Education	47.5%	52.7%	42.0% - 64.9%

Sources: *Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO. *Remaining indicators based on 2006 Census of Canada, Statistics Canada.*

Health Status

Self-reported health can show aspects of health not captured in other measures. Similar to Ontario's rates, more than 61.5% of LHIN residents rate their health as 'excellent' or 'very good' *(Source: Statistics Canada, Canadian Community Health Survey, 2009-10).* However, significantly more LHIN residents say they are limited in activities because of a physical or mental condition or health problem and have pain or discomfort that prevents activities.

Illness, Disease and Death

The LHIN's residents have significantly more arthritis/rheumatism compared to the province as a whole. Rates of asthma and high blood pressure are slightly but not significantly higher than Ontario rates. Diabetes rates, on the other hand, are comparable to the province *(Source: Statistics Canada, Canadian Community Health Survey, 2009-10).*

Death rates reflect the overall health of the population. Lower death rates show success in preventing, detecting, and treating disease, and reducing suicide. In 2007, there were 11,594 deaths among residents of the LHIN. Heart disease, lung cancer, and stroke were the top three leading causes of death. Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of life lost and hospitalization rates in the LHIN are higher than provincial rates *(Source: Death, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

Health Practices and Preventive Care

Poor health practices increase the risk of chronic disease, disability, and death. Relative to the province, more people in the LHIN smoke daily or occasionally, drink heavily, and are obese *(Source: Statistics Canada, Canadian Community Health Survey, 2009-10).*

Preventive health care services can help find disease early, which over the long term reduces illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as a whole. Among women in the LHIN, 71.7% had a Pap smear (for cervical cancer screening) within the previous three years, 73.1% received a routine mammogram in the previous two years, and 31.7% had a flu shot in the past year *(Source: Statistics Canada, Canadian Community Health Survey, 2005, 2008 and 2009-10).*

Most people get their care through their family doctors. Doctors also play a key role in coordinating care and managing chronic conditions. Most people (81.3%) in the LHIN talked, either in person or by phone, with a doctor in the last year. This is similar to the Ontario rate of 82.2% *(Source: Statistics Canada, Canadian Community Health Survey, 2009-10).*

Summary

The LHIN covers approximately 6,500 km^2, encompassing Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With approximately 1.4 million people, it includes small rural communities and large urban centres, with a population that is culturally and linguistically diverse.

Relative to Ontario, the LHIN has a higher percent of:

- lone parent families
- people limited in their daily activities
- daily or occasional smokers
- people who drink heavily
- people who are obese
- people with arthritis/rheumatism.

The LHIN also has:

- the most seniors of any Ontario LHIN
- a higher rate of premature death and hospitalization
- a lower percent of adults with post-secondary education.

Engaging our Communities

Community engagement is a core function of the LHINs. This function is written into the *Local Health System Integration Act (LHSIA)*, 2006 which created LHINs. As part of its work, the LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with Aboriginal, First Nations and Francophone communities. The LHIN recognizes, respects and seeks to understand and address the unique needs of its diverse communities.

Aboriginal Health Engagement

LHINs are mandated to work with Aboriginal communities for improved health and wellness. The LHIN has a responsibility to learn about and respect Aboriginal communities' approach to health and wellness and how this approach guides the identification of health needs and solutions. Respect for and inclusion of Aboriginal traditional practices with non-traditional health providers is essential for health solutions aligned with cultural identity, holistic health, and community values.

The LHIN's Aboriginal Health Network meets monthly to think about and share best practices on improving the health of Aboriginal people across the LHIN. The network, which includes representatives from Aboriginal health and social services from across the LHIN, finalized its Terms of Reference during a retreat in June 2011.

The purpose of the network is to create a forum that will harmonize the efforts of First Nations, Métis and urban Aboriginal health and social service providers toward creating a health system that:

- meets the holistic health needs of Aboriginal people across the region from an Aboriginal perspective
- integrates traditional Aboriginal knowledge and healing systems for healthy people and healthy communities
- commits to input from Aboriginal communities regarding present and future programs and services
- improves the capacity of a broad range of stakeholders to contribute to improved health outcomes of Aboriginal people
- liaises with the LHIN Board to ensure decisions positively impact Aboriginal health status and access to services.

The network decided one of its early priorities for action is children and youth, specifically within the context of mental health and addictions. Recognizing the importance of youth's voice in a strong future, two youth were recruited to join the network. These youth, along with the network's two youth mentors, held a digital storytelling workshop for 10 Aboriginal youth to learn the elements of storytelling and how to capture these stories digitally as they share and build stories of their own health care experiences. These stories will be an important supplement to existing data that will help shape the LHIN's work as it plans, funds and integrates the health care system. They will help highlight when the health system works well in supporting Aboriginal health and wellness and will help identify any gaps, challenges and opportunities. They will also help the LHIN to develop cultural sensitivity workshops for mainstream health care providers to help them think strategically about the needs of various populations, and to work together to improve the delivery of services to these populations.

During a three-day retreat in January 2012, the network established three priorities to address over the next three years, and will track and monitor key indicators (see chart below) as a measure of impact and progress in achieving desired results.

The Aboriginal Health Network outlines its priorities during a three-day retreat January 6-8, 2012.

Desired Result (Priority)	Primary Indicator
Aboriginal youth feel proud, respected and hopeful about their future	⇩ Youth suicide rate
Aboriginal people live long, healthy lives	⇩ Diabetes rate
Aboriginal people live in strong, stable and responsible families	⇩ Incidence of domestic violence

The network is developing an action plan to reduce the youth suicide rate, the diabetes rate, and the incidence of domestic violence among the Aboriginal population. Recognizing that many different factors contribute to achieving these results, the action plan identifies some of the other key networks, groups and organizations who have a role to play and describes actions they can take to impact the above indicators.

Francophone Health Engagement

The *French Language Services Act (FLSA), Ontario, 1986*, recognizes the contribution of the French speaking population to the historical, cultural and linguistic heritage of Ontario. The FLSA guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. To this end, LHINs plan and promote French language health services and engage the French speaking community in the process; French speaking residents and stakeholders know their communities best. The goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

Partners in Health

Prior to providing funding to an Entity under O.Reg.515/09 Engagement with the Francophone Community made under Section 16 of LHSIA, LHINs and the French Language Health Planning Entity must engage and enter into a funding and accountability agreement. The agreement sets out the roles and responsibilities of each party related to the provision of advice by the Entity on:

- methods of engaging its Francophone community
- the health needs and priorities of its Francophone community, including the needs and priorities of diverse groups within that community
- the health services available to its Francophone community
- the identification and designation of health service providers for the provision of French language health services in the LHIN
- strategies to improve access to, accessibility of and integration of French language health services in the local health system
- the planning for and integration of health services in French in the LHIN.

The HNHB LHIN, Waterloo Wellington LHIN, and the Entité de planification pour les services en français dans les régions Waterloo-Wellington, Hamilton-Niagara (the Entité) signed a five-year funding and accountability agreement starting April 1, 2011. The HNHB LHIN is the lead LHIN responsible for the provision of funding under the agreement.

The accountability agreement required the establishment of a Liaison Committee whose role is to develop appropriate mechanisms for ongoing dialogue and collaboration and a yearly Joint Annual Action Plan (JAAP) that sets out the objectives, priorities and actions each party will undertake in the current fiscal year.

In the first year of the agreement, the Joint Liaison Committee (JLC) was established, Terms of Reference were developed and a JAAP for 2011-12 was developed. Actions in the JAAP that the LHIN implemented include supporting the Entité in the process of starting up its operations, conducting orientation sessions to help the Entité better understand the health system and system capacity across the LHIN, to educate the Entité about the LHIN's strategic directions, local priorities, initiatives and processes and to discuss implications for French Language Services (FLS) development within this context. The Entité became fully operational with its own staff and office space early in 2012 and provided its first advisory report to the LHINs.

Listening and Learning

The mandate of the FLS Coordinator in the LHIN is to increase knowledge and awareness of FLS in order to improve access to quality health services in French, to ensure FLS processes are integrated into the LHIN's work as a Crown agency and as a planning body, to engage and liaise with health service providers (HSPs) in order to assist them in planning and implementing FLS for their Francophone clients, and to liaise with the Entité on an on-going basis to facilitate the implementation of actions in the JAAP.

As a result of this on-going work:

- LHIN-specific local indicators requiring FLS-identified HSPs to submit an FLS Implementation Plan (FLSIP) were included in service accountability agreements; such plans describe how an HSP plans to improve access to services in French which includes engagement with the francophone community to determine priority needs. In 2011-12, 77% of HSPs required to do so have submitted FLSIPs to the LHIN.
- 97% of FLS-identified and designated HSPs have submitted an FLS report to the LHIN compared to 39% last year.
- Three times more FLS-identified HSPs have accessed the Regional French Translation service funded by the Ministry of Health and Long-Term Care in 2011-12 than in 2010-11.
- Health care workers from FLS-identified HSPs are enrolled in a 'French as a second language' course designed for health care professionals.

The HNHB LHIN brought together FLS-identified agencies for a French language services information session.

Stakeholder Engagement

As part of a stakeholder engagement strategy, the LHIN Board and staff members meet with political representatives throughout the year. The Chair and CEO met with MPPs throughout the year. The focus of these meetings was to keep political representatives informed of LHIN initiatives and activities as well as to provide a forum for discussion about community health care needs, issues and concerns.

Behavioural Supports Ontario (BSO) Project

"I am who I am so help me continue to be me"

The BSO Project is a provincial project intended to improve the quality of care and quality of life for older Ontarians with cognitive impairments who often exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation.

HNHB, North Simcoe Muskoka, Central East and South East LHINs came together September 20-21, 2011 for a Value Stream Mapping event.

Community engagement played an important role throughout the planning, development and implementation of the LHIN's BSO Action Plan. Engagement occurred across various health care sectors, including Aboriginal and Francophone health service providers, primary care and specialized geriatric physicians, long-term care home medical directors and health service providers from all sectors. Specific engagement activities included a Value Stream Mapping event and an event focused on streamlining processes. During the value stream mapping event in September 2011, the BSO team also engaged a member of the community who participated as a family representative. As a result, this individual is an active member of the BSO Oversight Committee, which has and continues to meet monthly. Engagement activities continue through the various LHIN BSO committees.

These engagement opportunities have enabled health service providers and physicians to continue to provide content expertise and direction for system improvements across the LHIN. The community member continues to provide the family perspective to ensure that all improvements are developed in accordance with the LHIN's BSO value statement, 'I am who I am so help me continue to be me,' so that these directly improve the quality of care and quality of life for older adults with responsive behaviours and their caregivers.

System-wide Quality Improvement

Throughout the year, the LHIN engaged its HSPs and partners on advancing system-wide quality improvement. At the governance level, the LHIN held two sessions with the Boards and senior staff of hospitals and the Community Care Access Centre (CCAC) to discuss the progress and future of providing quality care for patients and their families. At these meetings, governors provided the LHIN with guidance and ideas for moving forward. The LHIN also worked with all providers across the continuum of care through a variety of networks, including: Clinical Vice Presidents, members of the Long-Term Care Home Network, and Executive Directors of Community Health Centres and mental health and addictions agencies.

Through this engagement, partners together advanced:

- a focus on the patient perspective
- fostering innovative ways of thinking
- sharing ideas and strategies
- using data to drive change and patient care.

Physician Engagement

Throughout 2011-12, Dr. Jennifer Everson, Physician Lead, Clinical Health System Transformation, continued to work with the leadership team in the development of a variety of physician networks. The Chief Medical Leaders group continues to meet monthly and work on their annual deliverables. This year, there has been considerable focus on developing an electronic credentialing process, antibiotic stewardship, and organization of a second education session for all physician leaders in the LHIN. This group is comprised of the Chiefs of Staff or Vice President Medicals of all LHIN hospitals.

The LHIN brought together and established a new network consisting of Diagnostic Imaging (DI) leaders. This group has implemented an interventional DI checklist and is engaged in the reduction of MRI and CT wait times.

The Obstetrical Network will be reviewing the data from the Hamilton Spectator's BORN series, which examines the health of mothers and babies across the province. The Network will develop best practices to improve identified areas, including screening and caesarean section (C-Section) rates.

With endorsement from the Ministry of Health and Long-Term Care, in February 2012, Primary Care Leads were introduced in each of the province's 14 LHINs to strengthen and further integrate primary care into health planning. Dr. Ross Male, who practices family medicine in Brantford, will work with the LHIN to ensure that primary care services are better integrated with the work of other health sectors. By working together, the LHIN and local health service providers continue to implement strategies to improve access to quality care for local residents.

Long-term care home Medical Directors have began to form networks to facilitate information sharing and the uptake of best practice protocols.

An innovative pilot is occurring in Port Colborne, where physicians are working together with their community in a virtual interprofessional care model. Early results signal potential for this model as an effective method of collaboration between physicians and allied health professionals.

Working Together for Better Quality Care

Focusing on Quality and Safety

To determine key priorities to address safety, effectiveness, access and patient satisfaction, the HNHB LHIN Board reviewed the LHIN's progress across a number of indicators. The Board, with guidance from the Board's Q&SC, identified three quality priorities: MRI and CT, Total Joint Replacements, and Hospital Avoidance.

Longer than average wait times for MRI and CT were identified by the Board as one of their key quality priorities. Based on evidence from Health Quality Ontario's *Quality Monitor 2011*, hospitals in our LHIN had opportunities to improve the access and efficiency of MRI and CT services for residents. The LHIN engaged hospitals and medical leaders to develop a balanced scorecard to set targets for improved efficiency and measure progress in achieving goals. This significant quality improvement project focused on process improvements, system access, supply and demand, and wait time performance. As of the fourth quarter of 2011-12, wait times for MRI and CT are below the LHIN target, and patients are receiving needed diagnostic procedures sooner.

Primary hip and knee replacement is important for the function and quality of life for many patients. The Board selected hip and knee replacements as its second key quality improvement priority. Patients across the LHIN currently experience different processes when going to hospital for orthopeadic surgery. Consistent processes are proven to lead to better patient outcomes. Under the leadership of the LHIN, the five hospitals offering primary hip and knee surgery and the Community Care Access Centre (CCAC), have been working on standardizing each stage in this process, including referrals, pre-operative assessment, in-hospital care and discharge planning and rehabilitation. This process improvement will involve management, physicians, and frontline staff. Our goal is to have one clinical pathway, patient education programs, and standard order sets across the LHIN. This will improve quality outcomes and enhance the patient experience.

Key components of quality improvement include monitoring key performance indicators and sharing best practices for safety. Data and information are vital enablers to advancing the LHIN's quality priority. The LHIN has developed simple, easy to use monitoring tools for health service providers to facilitate greater efficiency in monitoring indicators and goal-setting. Performance targets for a number of indicators are now at the fingertips of HSPs to allow for easy measurement and discussion. By using data more intelligently, the LHIN and HSPs can make more informed decisions about care delivery, resulting in improved health care experiences for residents.

Sharing best practices, successes and ideas drive quality improvement. The LHIN has brought HSPs together to ensure that best practices inform decision-making and result in improvement for patients. Hospitals and the CCAC create public Quality Improvement Plans (QIPs) as required by the *ECFAA*. The LHIN worked with HSPs to set priorities consistent with system-wide goals and focus efforts on setting reasonable but demanding targets to enhance patient safety and quality of care.

The LHIN Board approved an Enterprise Risk Management Framework to ensure that all key risks to achieving system-wide goals are identified, measured and mitigated wherever possible. Unlike risk management programs that focus only on insurance and liability, Enterprise Risk Management allows the organization to review all risks and opportunities available to achieve organizational and system goals. Through this process, the Board and LHIN staff monitor and act on risks to patients, finances, and quality of care. This program assists the LHIN in achieving its fiduciary responsibility of delivering better care, better value and better health.

Safety is paramount for patients. The LHIN has worked with HSPs to facilitate consistency and sharing of information for patients as they transition from one care provider to another. Avoidable readmissions to hospitals impact patient access, safety and costs. The LHIN led efforts with HSPs to identify key strategies to facilitate the smooth transfer of patients across the care continuum. This includes work on standardized discharge procedures and medication reconciliation.

Staff safety is vital for any organization. The Board approved an Occupational Health and Safety policy for the LHIN workplace. The policy sets out the mandatory procedures and educational requirements under legislation, but also demonstrates the efforts put in place to make our workplace as safe as possible. Staff safety is the responsibility of the LHIN's Occupational Health and Safety Committee and this committee provides reports to the Q&SC of the Board.

HNHB LHIN RNAO Best Practice Spotlight Organization Candidacy

The LHIN is one of 16 sites across Ontario that has been given the opportunity by the Registered Nurses Association of Ontario (RNAO) to become a Best Practice Spotlight Organization (BPSO). This program has completed its third year, and will continue its work through a collaboration of the participating organizations.

During the third year of this program, 12 organizations have continued to share resources and worked collaboratively to implement and evaluate RNAO Best Practice Guidelines (BPGs) across the continuum of care. Throughout the second and third years, organizations continued to implement standardized practices from the following BPGs: Prevention of Falls and Fall Injuries in the Older Adult; and Risk Assessment and Prevention of Pressure Ulcers.

Organizations use risk assessment tools and a common reporting system that facilitates quarterly monitoring of client outcomes. They also collectively developed a LHIN-wide policy to standardize and promote best practices when transferring patients between participating organizations. In collaboration with all 12 partners, the program will now focus on the selection, implementation and evaluation of new best practice guidelines to improve the quality of health care services.

On April 14 2011, more than 60 representatives from HNHB LHIN hospitals, the HNHB CCAC and Niagara Region Public Health gathered together in Grimsby for a day of networking and learning as part of the HNHB LHIN RNAO BPSO initiative.

Participating organizations include:

- Brant Community Healthcare System
- Haldimand War Memorial Hospital
- Hamilton Health Sciences
- HNHB CCAC
- Hotel Dieu Shaver Health and Rehabilitation Centre
- Joseph Brant Memorial Hospital
- Niagara Health System
- Niagara Region Public Health
- Norfolk General Hospital
- St. Joseph's Healthcare Hamilton
- West Haldimand General Hospital
- West Lincoln Memorial Hospital.

Senior Friendly Hospitals

Ontario's LHINs are leading a Senior Friendly Hospital Strategy – an initiative to improve seniors' health and prevent their physical and mental decline in hospital. By acting together, hospitals can improve the experience and outcomes of older adults in Ontario hospitals.

The Senior Friendly Hospital strategy aims to:

- improve the health, wellbeing and experience of seniors in Ontario hospitals, helping them get back home sooner and healthier
- improve seniors' ability to live independently and stay out of hospital
- enhance the value of health care dollars
- help reduce ALC through supporting people to transition to the right place of care after a hospital stay
- promote quality improvement initiatives that can be included in hospital QIPs as part of ECFAA.

As a first step, each hospital assessed their successful seniors' initiatives, and identified opportunities for improvement and action. All adult hospitals in Ontario have completed a Senior Friendly Hospital assessment. Summary reports for each LHIN were developed in collaboration with the Regional Geriatric Programs of Ontario. The summary report for the LHIN, *A Summary of Senior Friendly Hospital Care in HNHB LHIN Hospitals*, is available at www.hnhblhin.on.ca.

In January 2012, the LHIN brought representatives from each hospital together to share key successes and challenges to date, as hospitals work towards Senior Friendly Hospital Action Plans, responding to the recommendations in the local and provincial Senior Friendly reports.

Residents First

The LHIN is involved in a quality improvement initiative known as Residents First. This initiative supports long-term care homes in Ontario in providing an environment for their residents that enhances their quality of life. Residents First also facilitates comprehensive and lasting change by strengthening the long-term care sector's capacity for quality improvement. Over the past year, the LHIN's long-term care homes continued to work together to share knowledge, key learnings and successes.

Residents First is a provincial initiative made possible through the support of the Ontario Ministry of Health and Long-Term Care. Implementation is a team effort involving LHINs as well as organizations representing residents, their families and homes. These groups have input on an ongoing basis, as members of the provincial steering committee that is guiding the implementation of the initiative.

Health Professionals Advisory Committee (HPAC)

Since March 2008, the Health Professional Advisory Committee (HPAC) has played an important role in bringing insight from their respective sectors and perspectives to the LHIN. This committee has decided to focus on exploring opportunities to optimize interprofessional care and scopes of practice within the LHIN.

Last year, the HPAC developed five recommendations to enhance the scope of practice of allied health professionals across the LHIN. These include the adoption of a standard definition of interprofessional care (IPC), educating health professionals on the Health Professionals Act and its relationship to IPC, creating opportunities for discussion around key issues related to IPC, encouraging IPC development through knowledge exchange with providers, working with educational institutions, and identifying champions. Work continues on developing a clear implementation plan for these recommendations.

The work of this committee supports the advancement of the LHIN's interprofessional care priority as outlined in its Clinical Services Plan (CSP) and Integrated Health Service Plan (IHSP) 2010-2013.

In 2011, the LHIN undertook a recruitment process and as a result, two new members joined the committee. Melanie Fall-Stratton is a clinical dietician and Carmen Carmazan is a physiotherapist and a registered practical nurse.

Advancing Our Priorities

Now in the third year of implementation, the LHIN and its partners are making great progress in advancing its priorities as outlined in the IHSP 2010-2013. The themes from the CSP, approved by the LHIN Board in November 2009, are tightly woven into the IHSP, which was approved by the Board in December 2009.

Patient Flow -
Helping People get the Right Care, at the Right Time, in the Right Place
Alternate Care Settings
Emergency Department Capacity
Clinical Program Integration
Community Based Health Service Capacity
Aboriginal Health
Francophone Health
Chronic Disease Prevention and Management -
Reduce Prevelance of Chronic Disease and Improve Care Delivery
Mental Health and Addictions -
Linking Services for Prevention, Management and Recovery
Enablers for Transformation
eHealth
Inter Professional Care
Transportation
Partners for Change

Overview of Priorities, page 11, IHSP 2010-2013

Integration

One of the key purposes of LHSIA is to "provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks" *(Source: Ministry of Health and Long-Term Care (ministry), Local Health System Integration Act, 2006).*

In 2011-12, the LHIN developed two key documents framing our approach to integration and providing assistance to health service providers in thinking through their approach to integration. The first of these documents titled *"Moving Towards a New Model of Care: An Introduction to Integration at the HNHB LHIN"*, identifies integration as a key direction for the LHIN, highlighting our focus on integrated service delivery models. Integration is viewed as a "means to an end with the end being to increase the health of the population, enhance the individual experience of care, and ensure system sustainability".

To assist providers in looking for opportunities to coordinate, collaborate, partner, and even amalgamate with the client's needs at the centre of the system, a second resource document titled *"Health System Planning and You"* was developed. This document guides HSPs through a planning process that leads them to explore integration opportunities. Increasingly, the expectation is that HSPs will develop partnerships that integrate the system and find resources through the integration. Such integration must be based on an understanding of population and client need, and must organize the delivery of services

around the client in order to improve health outcomes, access to care, the individual experience to care, while at the same time leveraging resources that currently exist in the system.

In 2011-12, the LHIN continued to focus on three streams of integration activity, including:

- Clinical Program Integration – developing integrated clinical service delivery models across hospital sites.
- Community-based Capacity – developing community based integrated service delivery models in local geographic areas, starting with a focus on assisted living for high risk seniors.
- Support services (back-office integration) – opportunities for HSPs to share the cost and provision of back-office functions such as finance, Information Technology (IT), human resources, etc.

Interprofessional Care

For an update on interprofessional care, please see the HPAC section on page 18.

Clinical Program Integration

The focus over the past year has been on vascular, thoracic and oncology services. The Integrated Regional Vascular Program and the Thoracic Program were approved by the LHIN Board in 2011. Each of these programs is designed to provide care closer to home while ensuring quality of and access to care. Implementation planning for each of these programs utilizes standardization and best practices to provide residents with the care they need regardless of where they live.

An integrated partnership between the Juravinski Cancer Centre and Niagara Health System has been formalized with the establishment of a single radiation/oncology program at the Walker Family Cancer Centre. This integrated regional cancer program will implement a regional cancer informatics system to enable information sharing, share best practices and protocols to support standardization.

Community-Based Health Service Capacity

The LHIN's Clinical Services Plan (CSP) identified challenges within community-based health services, including: system navigation, variation in availability and access to services across the LHIN, and variation across the community sector related to assessment tools, referral practices, care planning, support for self-management and client health outcomes.

Linking People with the Right Community Services

The LHIN introduced a common assessment tool - InterResident Assessment Instrument Community Health Assessment (InterRAI CHA) in the community support services (CSS) sector.

The benefits of community support service agencies using this tool include:

- assists clients in accessing the most appropriate available services
- reduces duplication of assessments
- informs service plans
- further develops the practice of assessment and care planning
- informs decision-making and planning based on standardized, aggregate data
- facilitates inter-agency communication through a common language based on recognized data standards.

Planning began in 2010-11 with implementation planned in three phases beginning in April 2011 and completed by March 2012. A LHIN-wide InterRAI CHA Advisory Group met regularly and provided direction for the implementation of the tool.

This engagement has resulted in:

- endorsement of the tool for the benefit of clients
- agreement on timelines for training, implementation of the InterRAI CHA and the Integrated Assessment Record
- the identification of key issues and recommendations for a tailored approach to implementation that meets the needs of the LHIN
- ongoing discussions on client flow, care paths and the circle of care
- development of a shared assessment framework that was endorsed by community support service providers and is currently being pilot tested.

Linking the Right People with Food Services

The LHIN introduced a nutritional risk assessment screening tool in all LHIN-funded food programs. After a year of engaging the CSS sector, the LHIN was excited to see the full implementation of a nutritional risk assessment screening tool to prioritize client service needs and optimize the use of resources. This means that the seniors who have the highest nutritional needs are the most likely to receive services. Data shows that from the screening completed, most of the people who are currently getting meals are identified as high nutritional-risk.

Better Access to Transportation

Access to transportation has consistently ranked among the top three health system challenges for residents of the LHIN.

In 2011-12, the Canadian Red Cross led a voluntary integration bringing forward an integrated service delivery model for health related transportation. The intended outcomes are to increase capacity by increasing the number of rides to meet demand, reducing unfilled ride requests, expanding service area coverage, and to improve standards of practice and efficiencies. Key elements of the service coordination model include:

- central access - one number to call
- central intake software, common database and scheduling software
- common eligibility criteria, policies and procedures, and standard fares
- central marketing awareness

Upon approval of their respective Boards of Directors, the key partners signed a Memorandum of Understanding to participate in the new collaborative coordination model. The list of partners in the new coordinated transportation model is expected to grow as a broader range of non LHIN-funded transportation programs and services participate in the collaboration.

In 2011-12, the LHIN provided one-time capital investments in transportation of over $200,000 for replacement vehicles in Hamilton and Haldimand-Norfolk and for the purchase of a new fully accessible vehicle to provide transportation services for residents of Brantford and Brant County.

As part of its comprehensive review, Aging at Home (AAH) programs related to transportation were approved for continued based funding.

Better Access to Assisted Living Services

Research identified the greatest gap in the community sector in the LHIN is in assisted living/supportive housing for seniors. Inadequate access to assisted living services in the community for seniors in poor health leads to early admissions to long-term care, and contributes to high rates of emergency room visits and the number of days people spend waiting in hospital to move to a different care setting.

The LHIN established partnerships and a project plan to develop a demonstration model to enhance the capacity of assisted living services to serve seniors in poor health in their own homes and in supportive housing settings. This model aligns with the updated *Assisted Living Services for High Risk Seniors Policy, January 2011*, from the Ministry of Health and Long-Term Care. The demonstration model began May 2011.

Given the success of the demonstration model, the LHIN has moved forward with LHIN-wide planning with the establishment of local planning collaborative tables in Hamilton, Burlington, Haldimand-Norfolk, Niagara and Brant. These geographically-based, cross-sector planning tables will identify local service gaps and priorities for improving access to care, using the Ministry's *'Updated Assisted Living Policy for High Risk Seniors', January 2011*, as a framework for addressing service gaps for high risk seniors.

These local Community Continuum Collaborative Tables will help to:

- strengthen partnerships among health service providers to sustain collaborative, inter-sectoral and evidence-based planning and delivery of services
- improve coordination of services across the continuum of care to support seamless transitions across care settings
- improve access to care to enable frail/high risk seniors to live independently in the community
- optimize the use of existing resources by reducing duplication, realigning roles, sharing back office functions and advancing integration.

Mental Health and Addictions

One in five persons or 280,000 people, in the LHIN will be affected by mental illness at some point in their lives *(Source: Health Canada, A Report on Mental Illness in Canada, 2002)*. Approximately 42,000 people, or 3% of people in the LHIN, depend on alcohol or illicit drugs in a given year *(Source: Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008)*. Key issues facing people with mental health and addictions include social stigma, access to services and basic supports including housing, income and social inclusion.

Planning

Local networks in Hamilton, Haldimand, Norfolk, Niagara and Burlington, as well as the LHIN-wide Mental Health and Addictions Network, have been actively working on LHIN priority areas. Some examples include Early Psychosis Programs, improved access to psychiatrists, implementation of a common assessment tool, and building a continuum of crisis capacity.

In the HNHB LHIN:

- 10-20% of residents will have a substance use disorder in their lifetime.
- 70% of people with mental health issues have been diagnosed before age 18.
- 98,000 children and youth do not get the mental health treatment they need.

These networks meet on a monthly basis and input collected from these meetings has shaped the LHIN's approach to planning. Each geographic area of the LHIN has a different array of services available, clients with varying mental health and addictions needs, issues related to access, clinical specialty expertise and

rural/urban composition. This means a 'one size fits all' approach to planning will not be successful and engagement of local providers and consumers is essential to successful planning and implementation.

Identifying Areas for Health System Improvement

The LHIN hosted focus groups across the LHIN with key stakeholders from various care settings on reducing unplanned visits to the emergency department by persons with a mental health and/or addiction. This resulted in a more in-depth understanding of the issues and recognition of the importance of both hospital and community based providers involved in finding sustainable long-term solutions.

Over a one year period, 30 individuals with a mental health issue and/or addiction accounted for nearly 2,200 visits to hospital emergency departments. An analysis was conducted to understand why this occurred and to help identify areas for health system improvement. Representatives of LHIN hospitals and community based mental health and addictions providers met regularly to discuss this and have agreed to pilot a consistent approach to address this issue. Through this collaborative approach between hospital and community providers, system-wide improvements, issues and gaps in service were identified and priorities set. This planning process has shed light on how the system can be more responsive to meet people's needs.

Better Access to Mental Health and Addictions Services

A wide variety of programs and services have been funded to meet the mental health and addictions needs of residents in the LHIN, including:

- a 24-7 crisis call service and mobile mental health crisis service providing outreach through implementation of the Crisis Outreach and Support Team Niagara (COAST) – Canadian Mental Health Association Niagara is the lead organization
- expanding the continuum of crisis capacity through funding for nurses and social work positions in Brant, Burlington and Niagara crisis clinics
- expansion of Early Psychosis Programs in Niagara and Brant
- nurse practitioners and nurses are being introduced in Niagara, Haldimand-Norfolk and Brant through telemedicine to help address the lack of primary care and improve access to specialty clinicians.

Linking People with the Right Services

The LHIN has introduced the Ontario Common Assessment of Need (OCAN) tool with all mental health service providers. This tool identifies individuals' needs and helps match them to existing services. It will also help to identify any gaps in service. A LHIN-wide advisory group has been established to support the process of implementing the tool. Consultation with provider organizations and consumers has resulted in a tailored approach that meets the specific needs of the LHIN. The tool will also help to inform local, regional and provincial planning and decision-making, and will facilitate communication among mental health service providers. Mental health providers are near completion of the implementation of the OCAN tool and the Integrated Assessment Record (IAR). IAR implementation will:

- support a client centred approach to care
- ensure the secure transfer of personal health information
- facilitate faster care planning and collaboration
- result in workload reduction
- increase in the reliability and quality of client information.

Increased Access to Psychiatrists

A centralized approach to new sessional fee funding provides people with increased access to psychiatrists across the LHIN, particularly in underserved areas. Planning is aligned with the current provincial goals of addressing unattached patients, easing pressure on emergency rooms, and the provincial strategy on mental health and addictions. Planning has been directly informed through consultation with the local Mental Health and Addictions Networks as well as the HNHB LHIN Sessional Fee Advisory Group.

Chronic Disease Prevention and Management

More than one million people in the LHIN report having a chronic condition, such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). This number is steadily rising due to the LHIN's aging population. Among residents with diabetes, complications are experienced by many; each year more than 200 people in the LHIN have a foot or lower limb amputated due to complications with diabetes. A number of activities over the past year have contributed to better care for people with chronic conditions.

Better Access to Diabetes Services

The LHIN enhanced coordination and improved access to diabetes services by helping to identify and implement more local Diabetes Education Programs and by working with health service providers to identify opportunities to expand foot care services for people with diabetes. The LHIN implemented peritoneal dialysis in three long-term care homes. In addition to working with its partners to establish a new Self-Management Coordinating Centre, the LHIN also continued its partnership with the Diabetes Regional Coordinating Centre to develop a LHIN-wide approach to diabetes care. These activities helped to achieve the goals of the Ontario Diabetes Strategy.

Moving Forward on a LHIN-wide Falls Prevention Strategy

There were over 13,000 visits by seniors to a hospital emergency department and more than 3,800 seniors hospitalized as a result of a fall in 2010-11. Seniors who have multiple chronic diseases are often at risk of falls due to complications and health issues related to these conditions. Research shows a multi-factor approach to falls is effective in reducing the number and frequency of falling.

The following interventions were funded and implemented to reduce falls:

- best practice falls prevention exercise programs
- mobile continence care clinics
- mobility assessments (fitting for assistive devices)
- home safety assessments (identifies safety risks and helps to implement changes)
- foot care clinics for high risk seniors (i.e. diabetes and chronic kidney disease).

Aging at Home (AAH)

Aging at Home (AAH) is a provincial strategy that provides a continuum of community-based services for seniors and their caregivers to allow them to stay healthy and live independently and with dignity in their homes. The strategy also aims to decrease the number of individuals waiting in Ontario hospitals for an alternate level of care (ALC). Patients who have been identified as waiting for an ALC are individuals who are occupying acute care beds in hospitals, but would be better cared for in another setting, for example, in their own homes, supportive housing settings, or long-term care homes.

Through the AAH Strategy, the LHIN has received more than $33 million to fund local programs that provide services to seniors in the community, enabling them to lead healthy and independent lives while avoiding unnecessary visits to hospital.

This year, the LHIN evaluated all funded AAH programs to ensure they are meeting their intended objectives and are contributing to improved population health, client outcomes, and system sustainability. The Decision Making Framework and criteria were used to evaluate all programs, which includes four main categories: system alignment, population health, system performance and system values. Through the course of the review and discussions with program staff, several opportunities for operational improvements (to improve access, efficiency and/or effectiveness) were identified for AAH funded programs. Health service providers were engaged through meetings and site visits to gain a detailed understanding of programs and services under review. Staff had the opportunity to meet with clients, families and caregivers to better understand how programs helped them to maintain independence and to avoid inappropriate hospitalization.

The focus of funded programs is on getting people the best care in the right place, getting them home safely and quickly after a hospital stay, and finding them supports in the community rather than the emergency room.

eHealth

The eHealth Project Management Office (PMO) for the LHIN plays a lead role in harnessing information technology and innovation to improve patient care, safety and access for the residents of the LHIN in support of the government's health strategy. Provincially, eHealth Ontario has evolved Ontario's Electronic Health Record (iEHR) Strategy, moving from a centralist model to one of regional hubs.

LHINs are grouped into three hubs or 'eHealth clusters:'

- Southwest Ontario (SWO): Erie St. Clair, South West, Waterloo Wellington, and Hamilton Niagara Haldimand Brant.
- Greater Toronto Area (GTA): Central West, Mississauga Halton, Toronto Central, Central, Central East, and North Simcoe Muskoka.
- North East Ontario (NEO): South East, Champlain, North East, and North West.

Province-wide information sharing and access to provincial information assets is achieved by linking the regional hubs to a provincial hub. eHealth Ontario is establishing the information technology standards to be used in implementing each regional hub. SWO and NEO are building on the work of GTA to integrate and share data and have launched accelerated planning projects. SWO is positioned to rapidly deliver a first generation iEHR for approximately four million Ontarians that will span a significant portion of the continuum of care.

Integrated Decision Support (IDS) Warehouse

The Integrated Decision Support (IDS) Business Intelligence Solution is a powerful decision support system that supports system-wide planning and performance reporting. IDS is a centralized data warehouse containing current, detailed information for patients in hospital beds (acute, rehabilitation, mental health and

complex continuing care), emergency room visits, same day surgery, medical day care clinics, CCAC client and assessment data, Community Health Centre (CHC) client and provider data, and ALC Information System (ALC-IS) patients.

It is linked by an identification that is specific to an individual that connects data from all data sources allowing the approved users of the IDS to follow a patient's journey through the health care system. In addition to a patient's clinical information, hospital-specific financial and statistical information are available for three year trending. In the LHIN, over 10 hospital corporations representing 23 sites contribute data, in addition to Community Health Centres and CCAC data, as well as Cambridge Hospital in the Waterloo Wellington LHIN.

Over the next 18 months, additional hospitals from four other LHINs (Waterloo Wellington, Toronto Central, Southwest, and Champlain) are committed to or are in discussion about joining and leveraging IDS. New datasets related to ambulatory cancer centre patient data will be incorporated and those patient's journeys linked within IDS in the fall of 2012 (HNHB LHIN Regional MOSAIQ implementation). In addition, the exploration of adding EMS (Ambulance and Paramedic) information to enhance the Emergency Room patient journey reporting is underway, as well as improved system and infrastructure functionality to IDS is being undertaken.

There are over 250 registered users (primarily analysts). Integrating data from IDS into ClinicalConnect as part of a "portal to portal" approach is being considered since it can provide valuable complementary information to clinicians at the point of care and to assist emergency room providers.

ClinicalConnect

ClinicalConnect is a secure, provider portal or dashboard that gives authorized physicians and health care providers involved in a patient's circle of care, real-time, anytime and anywhere access to electronically stored patient records. ClinicalConnect is an integration framework that is key to the access and sharing of health information regionally across the continuum of care including provincial data sources as they become available.

Top row, left to right: Dale Maw, Senior eHealth Manager, WW LHIN; Hon. John Milloy, MPP Kitchener Centre; Greg A. Reed, President & CEO, eHealth Ontario; Hon. Sophia Aggelonitis, MPP Hamilton Mountain; Ted McMeekin, MPP Ancaster-Dundas-Flamborough-Westdale
Bottom row, left to right: Susan Barnard, patient and Hamilton resident; Dr. Barb Teal, Family Doctor, Hamilton; Dr. Mohamed Alarakhia, Family Doctor, Kitchener; Dale Anderson, Senior Consultant, Stakeholder Engagement, HNHB LHIN Project Management Office

Susan, a Hamilton resident, tells her story about how ClinicalConnect helped her learn very quickly the results of a biopsy at a joint HNHB and WW LHIN event August 9, 2011.

Today, ClinicalConnect provides a virtual Electronic Health Record for the HNHB and Waterloo Wellington (WW) LHINs, representing more than two million patients. It links data from 28 hospitals across the two LHINs. It also includes cancer care notes from the Juravinski Cancer Centre and information from the HNHB and WW Community Care Access Centres (CCACs).The remaining major hospital, Grand River Hospital and Cancer Centre is in progress.

Regional Diagnostic Imaging Project

The Regional Diagnostic Imaging project has continued to complete integration with regional hospitals and is also working to integrate and deploy the Diagnostic Imaging repository (DI-r) via ClinicalConnect. Live sites include eight hospitals in the LHIN and three hospitals in WW LHIN.

CCIM Repository for Mental Health and Addictions

The Community Care Information Management (CCIM) Repository for Mental Health and Addictions system is nearing completion. The database resides in a repository in the Erie St. Clair LHIN. The intent is to integrate this repository into ClinicalConnect in the future.

eHealth Ontario Projects

The LHIN was successful in receiving provincial eHealth Ontario funding to assist with a number of projects. This will help the LHIN advance its local strategic plan, aligned with government priorities. The LHIN is central to many projects and continues to work with other LHIN partners in Southwestern Ontario, eHealth Ontario and Canada Health Infoway. Examples of projects supported through funding from eHealth Ontario, Canada Health Infoway and the LHIN include:

- ClinicalConnect expansion and enhancement of the support and infrastructure.
- Integration of private laboratory data from the Provincial Ontario Lab Information System (OLIS) and database adding to the existing hospital based lab data within ClinicalConnect.
- Integration of the DI-r into ClinicalConnect to provide access to x-rays, MRI's and other images the patient may have had elsewhere in the region.
- Integration with provincial databases that enable improvements in patient transitional care.
- Mobile access to ClinicalConnect will be formally deployed assisted by Canada Health Infoway funding.
- Implementation of the Regional Oncology program ambulatory care software made possible with funding support from Canada Health Infoway.

Much of the success in obtaining funding for this work arises from the LHIN's interest in working with other LHIN partners. By building partnerships and coordinating resources, the four LHINs in the SWO regional hub are working toward building an efficient and effective e-health system for the residents of our communities.

Patient Flow

Patient Flow (PF) focuses on the movement of individuals across the health care system (continuum) from the community to acute in-patient hospital care, from acute to post acute care or home. It is not unexpected that situations will occur where individuals will experience a wait across the continuum. This often occurs in

hospitals, when individuals following acute treatment may experience waits to access a variety of post acute settings such as rehabilitation or even home if community services need to be arranged.

Issues arise when a high number of individuals are waiting in hospital for an ALC setting, or individuals experience long waits. Both situations can impede patient flow and negatively impact the individual and heath system.

Individual perspective:

- Individuals' recovery may be delayed or in the case of seniors may regress both physically and mentally while waiting for the appropriate post acute care setting.
- Unnecessary long hospital stays expose individuals to a higher risk of hospital acquired complications.

System perspective:

- Hospitals can become challenged when individuals need to be admitted for an acute illness or planned surgery if a high number of individuals that no longer require acute hospital care are waiting in hospital for an alternate level of care. This may result in the cancellation of elective services, long emergency department (ED) wait times, or delays in receiving required services.

One of the metrics used by the LHIN to measure the number of days an individual waits in hospital for an ALC is the acute ALC rate. A low rate means that individuals spend less time waiting in an acute hospital for post acute care. The post acute care setting individuals wait for depends on their immediate and long-term care needs and include: post acute restorative/convalescent care, complex care, rehabilitation services, home with community support services, mental health services, assisted living/supportive housing and long-term care home.

The LHIN monitors the number of days an individual waits in hospital for an ALC setting two ways:

- The total number of days individuals have waited in hospital for an ALC setting by the time they were discharged. These are referred to as closed cases.
- The number of days individuals still in hospital are waiting for an ALC setting. These are referred to as open cases.

The LHIN's PF Strategy for 2011-12 focused on sustaining and continuing to improve patient flow. Based on the experience of the two previous years, the LHIN recognized that sustained and continued improvement in patient flow could not be dependent on an individual organization or a single initiative; rather it must be viewed and approached as a 'system' issue where all components of a PF Strategy are implemented and aligned.

To assist in identifying system approaches to improving patient flow, the LHIN participated in two reviews; a four LHIN *Patient Flow Improvement Pilot* supported by PricewaterhouseCoppers LLP (PwC), and secondly the LHIN was selected as a site for review by Dr. Walker, Provincial ALC Lead, and the ALC Action Team. The findings and recommendations of these reviews guided the LHIN's approach to improving patient flow across LHIN hospitals.

In 2011-12, the LHIN developed a short term Action Plan that identified initiatives that could be immediately implemented to improve patient flow. These included:

- A Governance structure for ALC to increase accountability for improved patient flow, to identity patient flow as a key LHIN priority, and to facilitate implementation of patient flow improvement initiatives.
- The development and implementation, across all LHIN hospitals, of a standardized Intensive Case Management review process for all individuals waiting for an ALC setting for 40 or more days. This process facilitates collaboration with the goal of reducing the number of individuals that experience long waits in hospital.
- A focused strategy to facilitate the transition of individuals experience long waits in hospital for an ALC setting.
- Early identification of seniors at high risk who, due to their health status, are at risk of experiencing long hospital stays.
- A continued commitment to support individuals to return home following an acute hospital stay.

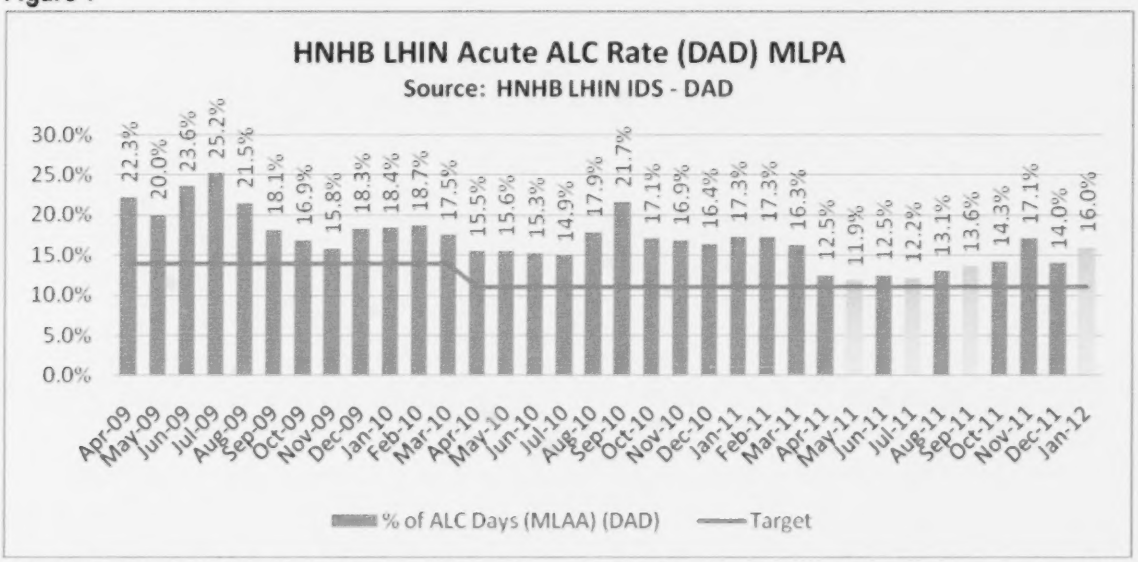
The LHIN works closely with its health service providers, the HNHB LHIN ALC Steering Committee and the HNHB CCAC to identify strategies that will improve patient flow.

Successes over the past year:

- Achieving the lowest number of ALC days in the first six months of 2011-12 in acute beds (12.94%) since 2007 *(Source: ALC Information System, October 2011). Refer to Figure 1.*
- Reducing the number of people waiting in hospital for long-term care (LTC) from 360 in August 2010 to 148 by April 1, 2012 *(Source: HNHB CCAC ALCIS April 26, 2012).*
- Reducing the number of individuals newly designated ALC to LTC in acute care from 85 noted in September 2010 to 30 in December 2011 *(Source: CCAC – Weekly Report).*
- Reducing the ALC rate in complex care beds from 36.5% in September 2010 to 19.9% in January 2012 *(Source: Ministry, LTCH System Report May 2011*).
- The implementation of an ALC strategy that 'bundled' initiatives to achieve sustainable change, including:
    - A standardized Intensive Case Management Review tool and process at all sites for all patients designated ALC at 30 days with a monthly review thereafter until successful discharge.
    - An escalation process across LHIN hospitals, where senior hospital and CCAC administrator's signoff is required prior to ALC-LTC designation. This is to ensure that all options have been explored and that waiting for LTCH in hospital is the only viable care option. Between July and September 2011 (Q2, 2011-12) hospitals reported the lowest number of individuals newly designated ALC- LTC in acute beds (88) since August 2009 *(Source: CCAC – Weekly Report).*
    - A focused strategy to assess the impact on clients who are experiencing long waits for LTCH implemented in September 2011. As of March 20, 2012, 143 individuals were discharged to the care setting that would best meet their total care needs (social, cognitive and physical). Together these individuals accumulated 25,998 ALC days *(Source: CCAC – Weekly Report).*

- Initiated daily operations groups (transitioned to three weekly calls) between the LHIN, senior hospital administrators and the CCAC to discuss each hospital's ALC population, barriers and solutions to transition.
- Implemented the LHIN's Integrated Complex Care Program in two hospitals.
- A 22.35% decrease in number of long stay LTCH applicants (excluding transfers) from June 2010 (2,547 in June 2010 and 1,978 in May 2011) *(Source: Ministry, LTCH System Report May 2011)*.
- Since Assess Restore (AR) and Slow Stream Rehabilitation (SSR) beds were operational: 79.3% of patients have been discharged home *(Source: HNHB LHIN Monthly AR Reports)*.
- Introduced a new AR stream for individuals that need a long period of restorative care (Assess- Restore Reactivation).

Figure 1



Note: The increased number seen in November 2011 and January 2012 is the result of successfully discharging a number of individuals that experienced long waits in hospital for the right care setting.

Emergency Department Wait Times

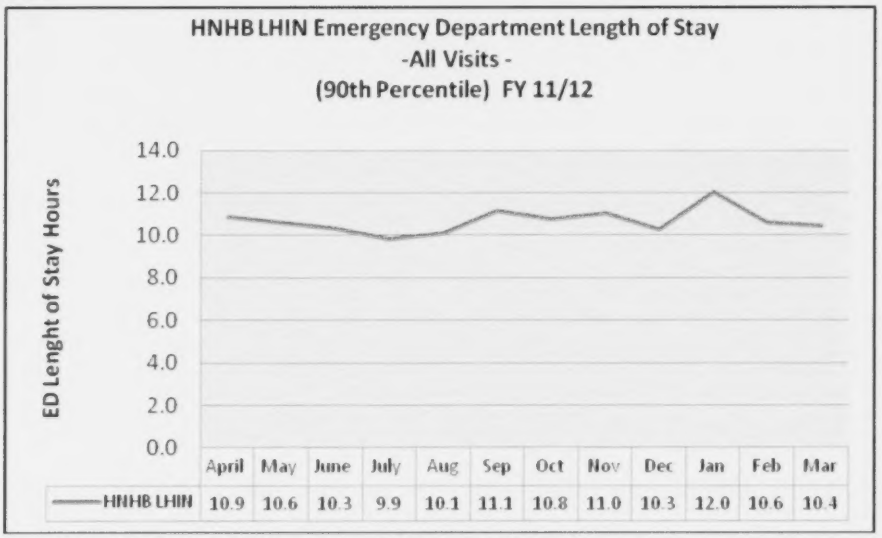
Improving timely access to ED services continued to be a priority for the HNHB LHIN in 2011-12. During the year, LHIN hospitals reported an increase in the number of ED visits compared to the same time period in 2010-11 (approximately 4,000 more visits from April 2011 to January 2012). There was also an increase in the number of seniors with complex conditions seen in the ED, which impacted the overall length of stay (LOS). Strategies to reduce wait times in the emergency department focused on reducing ED demand, improving efficiencies in the ED, and improving in-patient hospital flow.

ED wait times is the length to time it takes a person to complete their visit from the time of triage or registration (whichever comes first) until they leave the ED. This wait time is measured at the 90th percentile, which is the time the 9th out of 10 people waited. For example, if 10 individuals visited an emergency department and eight were treated and each left the ED within two hours of the time they were registered but it took the 9th person eight hours to complete their visit, then the 90th percentile wait time is eight hours.

The LHIN's overall ED LOS for patients remained stable until December 2011, when wait times started to increase, (refer to Figure 2). The increase in overall ED LOS can be attributed to the increased wait time experienced by individuals waiting in the ED for an in-patient bed (refer to Figure 3). Factors identified by LHIN hospitals impacting the admitted patient wait time include:

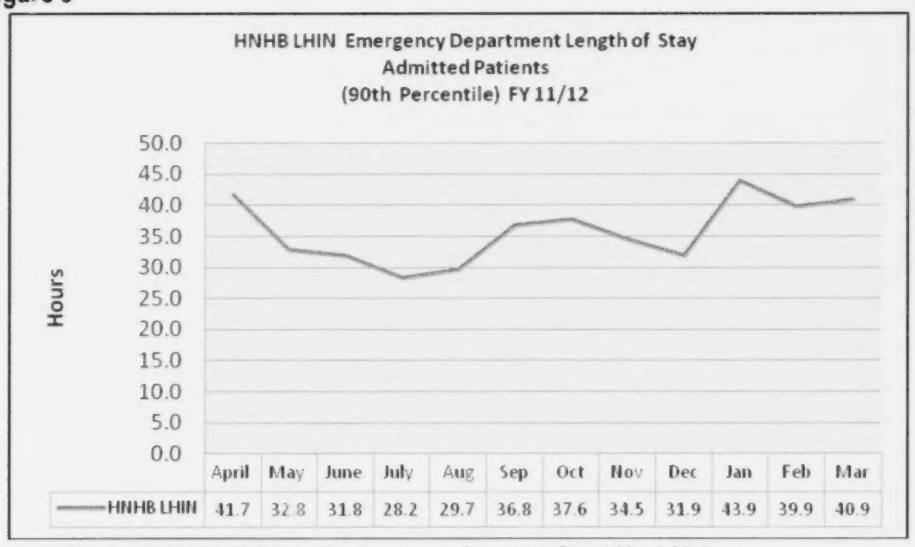
- increase in the number of ED visits
- increase in the number of seniors with more complex conditions presenting to the ED
- a higher number of individuals requiring isolation
- availability of inpatient beds
- LHIN long-term care homes with admission restrictions due to outbreaks (i.e. flu/influenza).

Figure 2



(Source: CCO-ATC CTAS Hospital Comparison Report March 2012).

Figure 3



(Source: CCO-ATC ER Pay for Results – Year 4- Operational Report March 2012)

Key Activities to Reduce ED Demand and ED Wait Times

Pay for Results (P4R)

In 2011-12, there were eight hospital sites with EDs participating in the Ministry of Health and Long-Term Care's Pay-for-Results (P4R) initiative. Through this strategy, hospitals focused on reducing the time people spend waiting in the emergency department by implementing initiatives to streamline patient flow. These initiatives included Rapid Assessment Zones for low acuity patients, Patient Flow Coordinators, enhancing ED support services, additional Triage Nursing time, additional ED Physician hours, and operating 'Express Units' that provide temporary in-patient capacity while patients are waiting to be discharged.

Participating HNHB LHIN Hospitals:

- Brant Community Healthcare System
- Hamilton Health Sciences
  - Hamilton General Hospital
  - Juravinski Hospital and Cancer Centre
  - McMaster Children's Hospital
- Joseph Brant Memorial Hospital
- Niagara Health System
  - St. Catharines General Hospital
  - Greater Niagara General Hospital
- St. Joseph's Healthcare Hamilton

New to the P4R program in 2011-12 was the introduction of the Medical Short Stay Unit (MSSU) model. These units provide additional in-patient beds and are targeted to individuals admitted through the ED and who are expected to be in the hospital for up to three days (72 hours). This program is expected to expedite the flow of ED admitted patients and assist hospitals to reduce the 90th percentile wait time for the ED admitted patient population. Three LHIN hospitals were operating MSSU in 2011-12: Hamilton Health Sciences' General site, St. Joseph's Healthcare Hamilton, and Niagara Health System's St. Catharines site.

ED Wait Times in 2011-12:

- In 2011-12, the eight LHIN P4R sites have collectively improved the Admitted Patient ED LOS by 6.3 hours (April 2011 to January 2012, 34.4 hours) over the previous year's baseline performance (40.7 hours), or a 15% performance improvement. For all LHIN EDs, collectively (year to date January 2012), the number of hours residents spent in the emergency department waiting to be admitted to a hospital bed decreased by 10.7 hours over April 2008.
- For non-admitted patients the LHIN P4R sites have remained stable, with very small improvement. Of note, the LHIN P4R sites report an increase in the number of non-admitted high acuity patient visits, which are equally resource and time intensive to reach the decision to not admit as the admitted patients. Collectively the LHIN P4R sites treat 86% of all high acuity patients within the seven hour target, and five out of eight sites improved over their baseline LOS. For low acuity patients, the overall wait time remained relatively constant. Collectively, the eight P4R sites improved over their baseline measure, while individually it was four out of eight sites improved.

Emergency Department Performance Improvement Program (ED PIP)

ED PIP applies LEAN methodology to hospital-wide patient flow processes by engaging multiple hospital departments focused on emergency department wait time improvement. ED PIP strategies focused on emergency department triage processes, streamlining patients by level of illness, improving processes for laboratory and diagnostic image testing, and improved discharge processes for in-patients to make room for the newly admitted ED patients.

In 2011-12, the last two of the LHIN P4R sites St. Joseph's Healthcare and NHS Greater Niagara General Site participated in the ED PIP program. New in 2011-12 was 'ED PIP Light Touch,' a less intense process improvement program, NHS-Welland site participated in this program.

Health Care Connect

This program, operated by the HNHB CCAC, connects residents without a family physician to primary care. In the first 10 months of 2011-12 (April 2011 to January 2012) 2,448 previously unattached patients were connected with a primary care provider *(Source: HNHB CCAC Monthly Data Report January 2012).*

Increased Access to Urgent Care Centres (UCC)

Residents with less acute emergent health care needs can be treated at urgent care centres quicker than emergency departments. The LHIN's sixth UCC opened April 2011 as part of the Hamilton Health Sciences Access to Best Care initiative. In 2011-12, two LHIN urgent care centres reported an overall maximum wait time for nine out of ten individuals of approximately three hours, compared to the LHIN overall wait time of 11 hours.

General Internal Medicine Rapid Assessment Clinics (GIMRAC)

In 2010-11 two GIMRAC Clinics opened: one at Hamilton Health Sciences' McMaster Site and St Joseph's Healthcare Hamilton's Charlton Campus. These clinics, funded through the LHIN's Aging at Home strategy, facilitates access to General Internal Medicine (GIM) consultations through an out-patient clinic. The program reduces ED wait times by providing access to General Internal Medicine physicians within a 24-48 hour period of time, thereby allowing ED physicians to safely discharge patients that can be seen on an out-patient basis rather than waiting in the ED.

Since April 1, 2011, the two GIMRAC clinics combined, reported seeing 2,618 new clients, 935 follow-up visits, 718 ED visits avoided (individuals referred to the clinics from sources other than emergency departments), and 252 early hospital discharges because of follow-up care provided in the clinic. Both programs reported a 52% reduction in the ED wait time for patients seen in the clinic that required a GIM consult compared to those who were seen in the ED for a GIM consult.

Expansion of Nurse Practitioners in Long-Term Care Homes

This program - the Nurse Led Outreach Team - allows residents to be treated in their long-term care homes, avoiding transfers to the emergency department or hospital which can be stressful for the resident and the resident's family. As of September 2011, 1,876 LHIN long-term care home residents were cared for by nurse practitioners. Based on those visits, it is estimated that 751 transfers from long-term care to emergency were avoided. The team also provided 129 educational in-services to build clinical capacity within the long-term care home sector across the LHIN.

Community Care Access Centre (CCAC) Case Managers

As of January 2012, 3,264 emergency department admissions were potentially avoided as a result of CCAC case managers being located in emergency departments. Where appropriate, CCAC case managers can arrange for care to be provided in the community rather than in hospital.

Screening Tool for High Risk Seniors

As mentioned earlier, the LHIN participated in a four LHIN *Patient Flow Improvement Pilot* supported by PricewaterhouseCoppers LLP (PwC). One of the findings from this report identified that of the two LHIN hospitals in the review, over 60% of individuals admitted to these hospitals and were later designated ALC were over the age of 75 and were from the community without home care services. Based on the findings, the LHIN in partnership with two of its hospitals and the HNHB CCAC piloted an ED Screening Tool to identify high risk seniors (over the age of 75) that presented to an emergency department and refer them to CCAC.

In three months, 340 individuals were identified and referred to CCAC. Of the 340 referrals, 196 individuals were not known to CCAC and 90 of the 196 were eligible for services. As a result, 2,318 personal support hours, 428 nursing visits and 117 therapy services visits have been provided.

Emergency Services Steering Committee

The LHIN's Emergency Services Steering Committee (ESSC) provides leadership to LHIN health service providers and the LHIN organization in the planning and implementation of initiatives to improve service quality and wait times for emergency services within the LHIN community.

In 2011-12, the ESSC approved one-time funding for 2012-13 to support:

- Community Referral by Emergency Medical Services (CREMS) project to embark on a LHIN-wide roll-out of this successful initiative in Hamilton.
- Phase two of an ED Diversion pilot project by the Niagara EMS "OMEGA" project.
- A quality initiative across all 13 EDs in the LHIN, with McMaster Emergency Medicine Research Group (MEMRG), reporting on compliance of seven quality of care indicators for EDs.
- Hamilton Health Sciences and St. Joseph's Healthcare Hamilton and community Mental Health and Addictions providers initiative to decrease ED use by the highest use individuals, and provide patient specific care planning forums.
- A patient flow initiative with Brant Community Healthcare System and a model of hospital-based nurse practitioners who work with long-term care homes and the Nurse Led Outreach Team, facilitating ED avoidance strategies, and improved discharge practices from hospital to long-term care.

In 2011-12, two ESSC funded projects focused on ED diversion completed their objectives:

- The Omega project (Niagara EMS), did a phase one feasibility study of low acuity 911 calls that had the potential to be diverted. It was found that implementing the triage software at the dispatch centre had the potential to divert 500 EMS calls per month, or up to 60% of low acuity calls if the right alternatives and infrastructure were in place. This will proceed to a second phase study.
- Hamilton EMS implemented CREMS in partnership with HNHB CCAC. Over 300 paramedics were trained to make community service referrals on behalf of residents who called 911. From October 2010 to October 2011, 428 referrals were made and 77% of individuals had new or enhanced CCAC services initiated.

Behavioural Supports Ontario (BSO) Project

Behavioural Supports Ontario is a provincial project aimed at enhancing services for older adults with complex behaviours wherever they live, through the development and implementation of new models of care that focus on **quality of care** and **quality of life.**

The BSO project is based on a framework that emphasizes: system coordination and management, integrated service delivery, and a better experience for patients and their caregivers.

In August 2011, the LHIN, along with three other Ontario LHINs, was identified as an Early Adopter LHIN to implement the Ontario's BSO framework and operational program model.

To guide local health system redesign for behavioural support services within the BSO framework, the LHIN in collaboration with its health care providers and other key stakeholders developed an Action Plan. The plan identifies improvement plans which will result in a desired future state by addressing current gaps and duplication in the system and enhancing and reconfiguring existing services. This future state will address the client's needs and support client and family-directed care along the continuum. The improvement plans have been developed based on the following client value statement that was identified during a value stream mapping session in September 2011: **"I am who I am so help me continue to be me."**

Key improvement strategies for the HNHB LHIN BSO Action Plan include:

- The development of a tool kit for consideration by those working in primary care to identify and manage individuals with responsive behaviours.
- Centralized information and referral process designed to link the client/family with appropriate services.
- The establishment of an integrated community lead agency model to coordinate services and create a single point of contact for clients/families.
- Interdisciplinary mobile teams in the community and long-term care who will build capacity and support smooth transitions for clients across the system.

Successes over the past year:

- Successful recruitment of staff for the long-term care home (LTCH) and community BSO models.
- Developed and tested new approaches to care for four LHIN BSO Improvement Plans.
- Endorsement of the HNHB LHIN BSO Action Plan by the BSO Provincial Resource Team and Health Quality Ontario (HQO) team.
- HNHB LHIN was approved as an early adopter LHIN to implement the BSO framework.
- Identification of a long-term care home as the lead employer for the BSO long-term care home staff.
- 63 of the LHIN's 86 LTCHs have signed a Memorandum of Understanding with the Lead LTCH for the BSO LTCH Mobile Team.
- Approved funding to support the education of more than 700 long-term care home staff in specialized approaches to caring for individuals with dementia.

Wait Times Strategy

The Wait Time Strategy is continuing to increase its efforts to reduce wait times for access to care, particularly for cancer, cardiac, diagnostic imaging, joint replacement and cataract services for all residents of the LHIN.

In 2011-12 the LHIN's commitment to its residents was to provide timely access to quality services that involved evidence-based outcomes, active engagement and value for money.

While the LHIN did not see a reduction in wait times for total hip and knee replacement and cataract surgery in 2011-12, the LHIN did show significant improvements in wait times for Diagnostic Imaging and year-end wait times are improving for cancer and cardiac bypass surgery.

The LHIN continued to face challenges in 2011-12 that limited reported wait time reductions including:

- Increased demand and decreased surgical capacity due to the availability of inpatient beds. Inpatient beds are impacted by unplanned hospital demand and the inability to discharge an individual to post acute level of care.
- Data quality and variations. The LHIN is working with hospitals to ensure accurate data consistent with provincial standards.
- Inconsistent hospital practices for care paths which impacts patient flow.

To improve access to health care and improve the quality of services in 2011-12 the LHIN, together with its health service providers across all sectors, undertook the following activities:

- Implemented hospital specific improvement strategies to reduce wait times, particularly in emergency departments and diagnostic imaging.
- Monitored wait time trends throughout the year to determine areas of need and implemented local and/or LHIN-based solutions which included reallocating funding based on need.
- Provided stakeholders the education and information to monitor performance and support ongoing improvements.
- Facilitated joint discussion to identify inequities, reduce variations in service and support quality improvement plans both within and between hospitals to maximize volume capacity and improve patient flow.
- Worked closely with provincial programs to ensure optimal cancer and cardiac services every step of the way.

HNHB LHIN Ministry-LHIN Performance Agreement (MLPA): Performance Indicators 2011-12

Performance Indicator	HNHB LHIN 11/12 Starting Point	HNHB LHIN 11/12 Target	Most Recent Quarter 11/12	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result
Emergency Room/Alternate Level of Care					
1. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution* **	**17.88%**	**11.00%**	**16.26%**	**47.8%**	**15.37%**
• The HNHB LHIN continued to show improvement in the percentage of ALC in 2011-12 from a starting point of 17.88% to a reported low of 12.94% in the first quarter of 2011-12. This is the lowest reported ALC rate the LHIN has achieved since 2007. The LHIN maintained a lower ALC rate ranging from 11.9% to 13.1% between April – August 2011. • The ALC rate increased in the most recent quarter of 2011-12 as a focused strategy for individuals experiencing long waits was prioritized in October 2011. Since this time, 169 individuals with more than a combined 30,000 ALC days have been successfully discharged to the most appropriate level of care. • The improvement in the percent ALC can be attributed to a bundle of strategies including a strong Home First philosophy, Intensive Case Management reviews for any individual experiencing less than 30 ALC days and restorative programs such as Assess Restore and Slow Stream Rehab that provide individuals with a slower and longer restorative time to recover and return home. • The LHIN anticipates continued improvements in the ALC rate in 2012-13.					
2. 90th Percentile ER Length of Stay for Admitted Patients	**38.92**	**28.30**	**42.03**	**48.5%**	**35.45**
• Admitted emergency room (ER) length of stay (LOS) has historically been the most challenging of ER metrics to improve. ER LOS is reflective of admitted patient flow within the hospital. 2011-12 saw an overall decrease in ED LOS of 3.4 hours (a 9% performance improvement), and remains 25% variance from target. • The first quarter showed significant improvement from April (40.4hrs) to July (28.6), with July ER LOS the lowest in the LHIN for the last four years and 1% variance from target. Two spikes in ER LOS occurred in September (37.1) and January (44.3), which decreased the improvement of the fiscal year as a whole. The spike in September is largely attributed to longer wait times reported by the NHS-St. Catharines, NHS-Greater Niagara and Joseph Brant Memorial Hospital (JBMH). The C.difficile outbreak NHS experienced in 2011 impacted its ER wait times as they adhered to isolation protocols. JBMH implemented new initiatives in 2011-12 to improve ER wait times. While they demonstrated substantial improvements; they experienced a number of months where wait times spiked to levels seen in 2010-11. • Factors influencing hospital ER wait times included: high numbers of admitted patients in the ER, infection control protocols, increasing high acuity and more complex cases with co-morbidities, outbreaks in long-term care homes in the community, and decreased access to services over the holiday season/breaks.					

• The LHIN meets monthly with hospitals with longer ER wait times to discuss strategies to improve performance.					
3. 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	**7.87**	**7.50**	**7.87**	**4.9%**	**7.75**
• While the LHIN demonstrated improvement in this metric, the LHIN finished the year 0.25 hours over the LHIN target which represents a 3% variance (and 2% performance improvement). • There is a four year trend of increasing High Acuity Patient volumes (CTAS 1-3) that has impacted achieving more significant gains. For 2011-12 the LHIN's ERs treated 5,800 more high acuity cases representing a 2% increase over the preceding fiscal year. From 2008-09 to the end of 2011-12 the LHIN has seen a 21% increase, or approximately 57,000 more high acuity visits. • Despite the continued increasing volume trend, the overall LHIN ER LOS improved in this patient group. • West Lincoln Memorial Hospital (WLMH), which has the highest ER LOS for this group, has entered into planning agreements with a partnering hospital to improve access to Diagnostic Imaging resources. Access to medical consultation and diagnostics in general is limited after hours (lab/ultrasound), impeding improvements until alternate arrangements are complete.					
4. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	**4.82**	**4.50**	**4.85**	**7.8%**	**4.87**
• The LHIN year-end wait time for this indicator was 0.37 hours from target or an 8% negative variance. The LHIN remains 0.57 hours from the overall provincial performance at year-end. • For the LHIN ER sites with greater than 30,000 annual visits (Pay-for-Results sites), this metric ranges from 3.4 to 6.4 hours. For non-P4R sites (<30,000 annual visits), the range is 1.9-6.0 hours. • Factors contributing to the wait times reported for individuals that are not admitted are: number of individuals waiting for an inpatient bed in the ER that require resources and stretcher space along with the time needed to complete medical tests (i.e. lab work, ultrasound). • LHIN hospitals have implemented Rapid Assessment Zones, Medical Directives, Physician See and Treat areas, and Nurse Practitioners to improve the flow and reduce wait time for individuals that are of the non-admitted low acuity patient group.					
Surgical Wait Times					
5. 90th Percentile Wait Times for Cancer Surgery	**61**	**58**	**71**	**22.4%**	**62**
• Cancer Surgery wait times remained fairly stable throughout 2011-12. The annual reported wait time of 62 days did not meet the LHIN's year-end target of 58 days but ended the year only one day higher than the start of the year. • In 2012-13, the LHIN's Regional Cancer Program priorities include: implementing an integrated cancer services plan for all LHIN hospitals which includes implementing a Regional Informatics Strategy, opening the Walker Family Cancer Center in St. Catharines, as well as strengthening the Regional Cancer Program including the implementation of a Regional Mobile Coach for increased screening.					

6. 90th Percentile Wait Times for Cardiac By-Pass Procedures	**34**	**48**	**35**	**-27.1%**	**46**
• The LHIN's wait time for elective cardiac bypass surgery in the most recent quarter was 35 days, and for year-end is 46 days lower than the LHIN target. • This metric reports only the time waited by individuals waiting electively for cardiac bypass surgery and as such is impacted by the number of individuals needing surgery on an urgent or semi-urgent basis. • The LHIN's cardiac surgery services are provided by one LHIN hospital - Hamilton Health Sciences. • The LHIN works with HHS and the MOHLTC provincial services unit to ensure HHS has the resources to meet residents' needs for this surgery.					
7. 90th Percentile Wait Times for Cataract Surgery	**127**	**120**	**154**	**28.3%**	**143**
• Cataract Surgery wait times ended the year at 143 days. This wait time is lower than the provincial target of 182 days but above the LHIN target of 120 days. • Additional resources made available for surgery in the last quarter of 2011-12 accounted for the improvement in wait times reported at year-end.					
8. 90th Percentile Wait Times for Hip Replacement	**201**	**177**	**223**	**26.0%**	**229**
• Wait times for Total Hip Replacement Surgery in the LHIN have made steady improvements since the end of the third quarter. The annual wait time was reported at 229 days, but the LHIN wait time reported in March 2012 was below both the LHIN target of 177 days and the provincially reported wait times. • March 2012 wait times for Total Hip Replacement Surgery were the lowest wait times reported in the LHIN since August 2010. • More patients requiring Total Joint Replacements accessed the Regional Joint Assessment Program (RJAP) in 2011-12 than any previous year. Four out of five LHIN Hospitals are now operating the RJAP in 2012-13.					
9. 90th Percentile Wait Times for Knee Replacement	**217**	**182**	**302**	**65.9%**	**267**
• The year-end annual wait times for Total Knee Replacement Surgery was reported at 267 days, 85 days above the LHIN and provincial wait time target of 182 days. • Projects underway in 2012-13 between the LHIN and the HNHB LHIN Orthopedic Working Group are aiming at standardizing clinical pathways and improving efficiencies and the patient experience. • The LHIN will be meeting with hospitals in the LHIN that are driving the high wait times to develop and implement improvement plans for 2012-13.					
Diagnostic Wait Times					
10. 90th Percentile Wait Times for Diagnostic MRI Scan	**119**	**88**	**79**	**-10.2%**	**91**
• MRI wait times ended the year at 91 days, three days above the LHIN target, and 28 days below the LHIN starting point in 2011-12. • Diagnostic Imaging improvement plans initiated by the LHIN in 2011-12 with key hospitals has resulted in the lowest reported MRI wait times for the LHIN since the inception of Wait Time Strategy reporting. • As of March 2012 four out of five LHIN hospital wait times are below the LHIN target of 88 days.					

11. 90th Percentile Wait Times for Diagnostic CT Scan	**43**	**43**	**44**	**2.3%**	**45**

- CT wait times have been fairly consistent throughout 2011-12 and have an annual wait time of 45 days, two days above the LHIN target and the 2011-12 starting point.
- CT wait times for the LHIN in March 2012 were reported at 39 days, which is the lowest wait time reported in the LHIN since the inception of Wait Time Strategy reporting.
- Continuing collaboration between hospitals as well as implementation of improvement strategies by all LHIN hospitals will help to maintain improved access to Diagnostic Imaging into 2012-13.

Excellent Care for All/Quality

12. Readmission within 30 Days for Selected CMGs**	**15.10%**	**14.00%**	**16.29%**	**16.4%**	**15.62%**

- The percentage of patients readmitted for the selected CMGs remained relatively constant over the time period (2011-12). The LHIN implemented a number of strategies to address appropriate admissions and readmissions to hospitals.
- Individuals aged 75 plus are screened using an evidence-based screening tool that screens individuals at risk for ER visits/hospitalizations. Individuals who are part of this pilot and meet the triggers of the tool are referred to the CCAC for new or enhanced services or information and referral to community services such as Meals on Wheels.
- The LHIN is piloting an Early Intervention Screening Tool for individuals 75+ at two LHIN hospitals. The tool is a modified interRAI ER Screener and is being tested at Brant Community Healthcare System and Norfolk General Hospital. At third quarter, 340 referrals to CCAC were generated from the sites. Of the 340 referrals, 196 clients were not known to CCAC, 90 were eligible for CCAC services and 106 were not eligible. 144 were known to CCAC and were currently receiving services. Of the clients that were known to CCAC a follow up visit/contact was completed by their case manager.
- Self management is a key strategy to keep individuals healthy and in their homes. Current health service provider training in self-management supports and programs and chronic disease self-management training is being provided for individuals with diabetes or at risk of developing diabetes.

Mental Health and Substance Abuse

13. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	**18.40%**	**18.40%**	**21.33%**	**15.9%**	**19.93%**

- Although the LHIN did not achieve its year-end target for this metric, there has been a number of initiatives that have been implemented this year:
  - The "Progress Report: Repeat Visits to the Emergency Department (ED) by Persons with a Mental Health and Addiction (MH&A)" was completed in January 2012, and will be used to facilitate discussion and actions with providers throughout the LHIN.
  - Implementation of sessional fee funding has allowed better access to psychiatrists in under serviced areas of the LHIN.
  - OCAN implementation is near completion with mental health providers.
- New investments have been made to the continuum of the community based mental health and addictions services including:

- Social workers/crisis management positions in Brant, Niagara and Burlington.
- Expansion of early psychosis program in Haldimand-Norfolk, Niagara and Brant.
- Nurse and Nurse Practitioner positions via telemedicine in Niagara, Haldimand-Norfolk and Brant.
- Specialized geriatric services in Haldimand-Norfolk and Niagara.
- Early Psychosis programs in Niagara and Brant.
- Support for community mental health in-patient eating disorders program in Hamilton.

14. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	**21.40%**	**21.40%**	**23.02%**	**7.5%**	**22.40%**

- There is a high proportion of individuals with concurrent disorders (substance abuse and mental health issues) in the LHIN. Health service providers have identified this population as challenging to serve.
- The LHIN will not achieve its year-end target and repeat unplanned ER visits have increased for this population.
- There are eight health service providers in the LHIN whose primary focus is persons with substance abuse conditions. The range of services includes residential treatment services, withdrawal management programs, problem gambling programs, assessment, treatment/counseling, education/health promotion, peer support and day programs. Current research on concurrent disorders suggests that there is a high prevalence that individuals with a substance abuse problem will also have a mental health issue. As such, the LHIN has chosen not to separate these indicators and the strategies outlined focus on this dual approach.
- New investments have been made to addictions supportive housing and case management; residential addictions services received funding to upgrade their equipment and facilities.

Access to Community Care					
15. 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)	**32.00**	**27.00**	**25.00**	**-7.4%**	**29.00**

- While the LHIN demonstrated a three day improvement in this metric during the year, the LHIN finished the year two days above the LHIN target.
- Higher wait times (54 days) reported for the period January – March 2011 impacted the LHIN's wait time. This peak in wait times was the result of the LHIN approving one-time funding to reduce the number of individuals identified as low care needs waiting for community support. As these individuals received service they were removed from the wait list resulting in a spike in the reported wait times.
- In 2011-12, to optimize community support service capacity, the LHIN approved additional funding to community support agencies to provide support for clients on the CCAC wait list for personal support services.

** A negative percentage means the LHIN is below its target*
*** FY 2011/12 is based on most recent four quarters of data (Q3 2010/11 - Q2 2011/12) due to availability*
**** FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 - Q3 2011/12) due to availability*

Financial statements of

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2012

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2012

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of financial activities 4

Statement of changes in net debt 5

Statement of cash flows 6

Notes to the financial statements 7-15

Deloitte

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2012 and the results of its financial activities, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 30, 2012

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**1,136,961**	1,869,146
Accounts receivable - e-Health funding	**200,000**	-
HST receivable	**32,298**	49,796
Accounts receivable - other	**92,991**	-
Due from MOHLTC to Health Service Providers ("HSPs") (Note 9)	**5,292,440**	11,338,713
	6,754,690	13,257,655
Liabilities		
Accounts payable and accrued liabilities	**853,210**	1,077,030
Due to the MOHLTC (Note 3b)	**635,488**	851,197
Due to HSPs from MOHLTC (Note 9)	**5,292,440**	11,338,713
Due to the LHIN Shared Services Office (Note 4)	**-**	4,089
Deferred capital contributions (Note 5)	**155,301**	311,967
	6,936,439	13,582,996
Commitments (Note 6)		
Net debt	**(181,749)**	(325,341)
Non-financial assets		
Prepaid expenses	**26,448**	13,374
Capital assets (Note 7)	**155,301**	311,967
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (Unaudited) (Note 8)	2012 Actual	2011 Actual
	$	$	$
Revenue			
MOHLTC / E-Health funding			
HSPs transfer payments (Note 9)	2,517,047,040	2,673,146,753	2,600,261,574
Operations of LHIN	5,174,872	5,174,872	5,174,872
E-Health (Note 10a)	600,000	600,000	600,000
E-Health-Physician Demonstration Project (Note 10a)	-	-	200,000
Residents First (Note 10b)	-	-	498,500
ER/ALC Performance Lead (Note 10c)	-	100,000	100,000
French Language Services (Note 10d)	-	106,000	74,670
French Language Planning Entity (Note 10d)	-	411,693	152,924
Emergency Dept LHIN LEAD (Note 10e)	-	75,000	75,000
Critical Care LHIN LEAD (Note 10f)	-	75,000	75,000
Aboriginal Planning (Note 10h)	37,500	37,500	37,500
Behavioural Support Ontario (Note 10i)	-	750,000	-
Primary Care LHIN Lead (Note 10g)	-	43,750	-
Amortization of deferred capital contributions (Note 5)	-	156,666	185,756
	2,522,859,412	2,680,677,234	2,607,435,796
Funding repayable to the MOHLTC (Note 3a)		(747,488)	(851,197)
	2,522,859,412	2,679,929,746	2,606,584,599
Expenses			
Transfer payments to HSPs (Note 9)	2,517,047,040	2,673,146,753	2,600,261,574
General and administrative (Note 11)	5,174,872	5,219,538	4,863,116
E-Health (Note 10a)	600,000	600,000	600,000
E-Health-Physician Demonstration Project (Note 10a)	-	-	200,000
Residents First (Note 10b)	-	-	162,855
ER/ALC Performance Lead (Note 10c)	-	100,000	100,000
French Language Services (Note 10d)	-	106,000	60,516
French Language Planning Entity (Note 10d)	-	151,822	152,924
Emergency Dept LHIN LEAD (Note 10e)	-	73,900	74,364
Critical Care LHIN LEAD (Note 10f)	-	73,896	72,167
Aboriginal Planning (Note 10h)	37,500	37,500	37,083
Behavioural Support Ontario (Note 10i)	-	407,837	-
Primary Care LHIN Lead (Note 10g)	-	12,500	-
	2,522,859,412	2,679,929,746	2,606,584,599
Annual surplus and closing accumulated surplus	-	-	-

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012		2011
	Budget (Unaudited) (Note 8)	Actual	Actual
	$	$	$
Annual surplus	-	-	-
Change in other non-financial assets	-	**(13,074)**	3,619
Acquisition of capital assets	-	-	(16,105)
Amortization of capital assets	-	**156,666**	185,756
Decrease in net debt	-	**143,592**	173,270
Opening net debt	-	**(325,341)**	(498,611)
Closing net debt	-	**(181,749)**	(325,341)

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	**156,666**	185,756
Less items not affecting cash		
Amortization of deferred capital contributions (Note 5)	**(156,666)**	(185,756)
Changes in non-cash operating items		
(Increase) decrease in accounts receivable - other	**(92,991)**	6,634
(Increase) decrease in accounts receivable - MOHLTC / e-Health	**(200,000)**	35,000
Decrease (increase) in HST receivable	**17,498**	(49,796)
Decrease (increase) in due from MOHLTC to HSPs	**6,046,273**	(9,963,913)
(Decrease) increase in accounts payable and accrued liabilities	**(223,820)**	521,754
(Decrease) increase in due to the MOHLTC	**(215,709)**	796,334
(Decrease) increase in due to HSPs from MOHLTC	**(6,046,273)**	9,963,913
(Decrease) increase in due to the LHIN Shared Services Office	**(4,089)**	9,057
(Increase) decrease in prepaid expenses	**(13,074)**	3,619
	(732,185)	1,322,602
Capital investment		
Acquisition of capital assets	-	(16,105)
Financing transaction		
Capital contributions received (Note 5)	-	16,105
Net change in cash	**(732,185)**	1,322,602
Cash, beginning of year	**1,869,146**	546,544
Cash, end of year	**1,136,961**	1,869,146

Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2012

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry – LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC"). These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2012.

The LHIN statements do not include any MOHTLC managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital asset and impairment in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC/eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC and eHealth Ontario.

a) The amount repayable to the MOHLTC/eHealth Ontario related to current year activities is made up of the following components:

	Funding Received	Eligible Expenses	2012 Excess Funding	2011 Excess Funding
	$	$	$	$
Transfer payments to HSPs	2,673,146,753	2,673,146,753	-	-
LHIN operations	5,331,538	5,219,538	112,000	497,512
Behavioural Supports Ontario	750,000	407,837	342,163	
E-Health	600,000	600,000	-	-
French Language Planning Entity	411,693	151,822	259,871	-
French Language Services	106,000	106,000	-	14,154
ER/ALC Performance Lead	100,000	100,000	-	-
Emergency Dept. LHIN LEAD	75,000	73,900	1,100	636
Critical Care LHIN LEAD	75,000	73,896	1,104	2,833
Primary Care Lead	43,750	12,500	31,250	
Aboriginal Planning	37,500	37,500	-	417
E-Health-Physician Demonstration	-	-	-	-
Residents First	-	-	-	335,645
	2,680,677,234	2,679,929,746	747,488	851,197

b) The amount due to the MOHLTC/eHealth Ontario at March 31, 2012 is made up as follows:

	2012	2011
	$	$
Due to MOHLTC, beginning of year	851,197	54,863
Funding repayable related to current year activities to the MOHLTC (Note 3a)	747,488	851,197
Amount recovered by the MOHLTC during the year	(963,197)	(54,863)
Due to MOHLTC, end of year	635,488	851,197

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	**311,967**	481,618
Capital contributions received during the year	-	16,105
Amortization for the year	**(156,666)**	(185,756)
Balance, end of year	**155,301**	311,967

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years and thereafter are as follows:

	$
2013	157,275
2014	163,313
2015	172,786
2016	172,786
2017	172,786
Thereafter	172,786

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Capital assets

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment, furniture and fixtures	**129,581**	**129,581**	-	80,613
Computer equipment	**471,438**	**431,725**	**39,713**	1,278
Leasehold improvements	**572,444**	**456,856**	**115,587**	230,076
	1,173,463	**1,018,162**	**155,301**	311,967

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of financial activities reflect the initial budget at April 1, 2011. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,673,146,753 is derived as follows:

	$
Initial budget	2,517,047,040
Adjustment due to announcements made during the year	156,099,713
Final budget	2,673,146,753

The final LHIN general and administrative budget of $7,373,815 is derived as follows:

	$
Initial budget	
LHIN operations	5,174,872
E-Health	600,000
Aboriginal Planning	37,500
Additional funding received during the year for	
Stabilization increase	-
French Language Planning Entity	411,693
French Language Services Coordinator	106,000
ER/ALC Performance Lead	100,000
Emergency Dept. LHIN LEAD	75,000
Critical Care LHIN LEAD	75,000
Primary Care Lead	43,750
Behavioural Support Ontario	750,000
Final budget	7,373,815

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,673,146,753 (2011 - $2,600,261,574) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2012 as follows:

	2012	2011
	$	$
Operation of hospitals	**1,815,165,386**	1,781,194,426
Capital contributions - Health Infrastructure Renewal Fund	**-**	5,119,191
Grants to compensate for municipal taxation - public hospitals	**458,100**	458,100
Long term care homes	**434,978,512**	411,353,925
Community care access centres	**259,534,247**	248,141,094
Community support services	**42,481,395**	41,210,576
Acquired brain injury	**6,612,526**	6,429,869
Assisted living services in supportive housing	**25,735,425**	24,178,932
Community health centres	**23,113,795**	20,909,757
Community mental health addictions program	**65,067,367**	61,265,704
	2,673,146,753	2,600,261,574

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As of March 31, 2012 an amount of $5,292,440 (2011 - $11,338,713) was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's financial activities and is included above.

10. Other funding initiatives

a) *E-Health*

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $600,000 (2011 - $800,000). $600,000 of these funds were used toward initiatives in support of the Project Management Office for 2012 update of the E-Health strategic plan and $nil (2011 - $200,000) were used for the Physician Demonstration Project

b) *Residents First*

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding, on behalf of all the LHINs, in the amount of $nil (2011 - $498,500) for all Residents First initiatives throughout the province. As directed by the MOHLTC, these funds were used to support training of staff that would result in performance improvement in Long-Term Care homes and help to reduce pressures on the Emergency Departments. Residents First supports long-term care homes in Ontario in providing an environment for their residents that enhances their quality of life and facilitates comprehensive and lasting change by strengthening the long-term care sector's capacity for quality improvement.

c) *ER/ALC Performance Lead*

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $100,000 (2011 - $100,000). These funds were used to support the activities of the ER/ALC Coordinator.

d) *French Language Services*

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $517,693 (2011 - $227,594). Of this amount, $106,000 was used to support the French Language Services Coordinator role (2011 - $74,670) and $411,693 was included in the initial allocation for the French Language Planning Entity (2011 - $152,924).

10. Other funding initiatives (continued)

e) Emergency Department LHIN LEAD

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2011 - $75,000). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

f) Critical Care LHIN LEAD

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2011 - $75,000). These funds were used toward initiatives in support of Critical Care LHIN LEAD activities.

g) Primary Care LHIN LEAD

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $43,750 (2011 - $nil). These funds were used toward initiatives in support of Primary Care LHIN LEAD activities.

h) Aboriginal Planning

During fiscal 2012, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $37,500 (2011 - $37,500). These funds were used to support Aboriginal Planning activities.

	2012	2011
	$	$
Travel	**2,298**	487
Salaries and benefits	**12,229**	32,349
Community Engagement	**19,942**	-
Meeting expenses	**3,031**	4,247
	37,500	37,083

i) Behavioural Supports Ontario (BSO) Initiative

The Ministry of Health and Long-Term Care provided one time funds of $750,000 (2011 - $nil) to the LHIN to support the successful implementation of the local action plan for the BSO project under our transfer payments to our HSPs. The BSO project was created to enhance services for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live, at home, in long-term care or elsewhere.

11. General and administrative expenses

The Statement of financial activities presents the expenses by function. The following classifies general and administrative expenses by object:

	2012	2011
	$	$
Salaries and benefits	**3,727,382**	3,384,397
Board Chair per diems	**20,650**	60,725
Directors' per diems	**62,200**	62,550
Board expenses	**17,994**	24,383
Travel	**36,470**	46,389
Consulting services	**200,057**	47,968
Banking services		
Community forums and communication	**47,418**	51,717
Supplies, equipment, maintenance, other	**84,816**	248,715
Occupancy costs	**363,890**	341,021
Amortization	**156,666**	185,756
Shared services	**501,995**	409,495
General and administrative expenses	**5,219,538**	4,863,116
E-Health	**600,000**	600,000
E-Health-Physician Demonstration Project	**-**	200,000
Residents First	**-**	162,855
ER/ALC Performance Lead	**100,000**	100,000
French Language Services	**106,000**	60,516
French Language Planning Entity	**151,822**	152,924
Emergency Dept. LHIN LEAD	**73,900**	74,364
Critical Care LHIN LEAD	**73,896**	72,167
Primary Care LHIN LEAD	**12,500**	-
Aboriginal Planning	**37,500**	37,083
Behavioural Supports Ontario	**407,837**	-
	6,782,993	6,323,025
Reconciliation to MOHLTC approved budget		
General and administrative and initiatives expenses	**6,782,993**	6,323,025
Less: amortization	**(156,666)**	(185,756)
Add: due to MOHLTC	**747,488**	851,197
Add: purchase of tangible capital assets	**-**	16,105
	7,373,815	7,004,571

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 35 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $293,761 (2011 - $245,987) for current service costs and is included as an expense in the Statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2011. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative figures

Certain comparative numbers have been changed to conform to the current year presentation.

Board Members

(as of March 31, 2012)

Michael P. Shea
Chair

Bob Lawler
Vice Chair

Douglas Archibald
Board Member

Nathalie Brown
Board Member

Ruby Jacobs
Board Member

Bob Lawler
Board Member

Helen Mulligan
Board Member

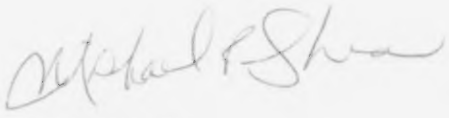
Laurie Ryan-Hill
Board Member

Mervin Witter
Board Member

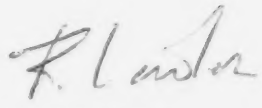
Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2012.



Michael P. Shea
Chair, Board of Directors



Bob Lawler
Vice Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

LHIN Contact Information

Telephone:
905.945.4930
1.866.363.5446

Fax:
905.945.1992

Email:
hamiltonniagarahaldimandbrant@lhins.on.ca

Address:
264 Main Street East
Grimsby, ON L3M 1P8

Website:
www.hnhblhin.on.ca

YouTube
www.youtube.com/user/hnhblhin

twitter
@HNHB_LHINgage

ISSN 1911-2912
146 June/12

© 2012 Queen's Printer for Ontario

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé